HAWAII ADMINISTRATIVE RULES

TITLE 17

DEPARTMENT OF HUMAN SERVICES

SUBTITLE 12 MED-QUEST DIVISION

CHAPTER 1737

SCOPE AND CONTENTS OF THE FEE FOR SERVICE MEDICAL ASSISTANCE PROGRAM

Subchapter 4 Long Term Institutional Services

Subchapter 5 Preventive and Rehabilitative Services

Subchapter 6 Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

Historical Note: This chapter is based substantially upon chapter 17-1370. [Eff 6/29/92; am 11/12/93; am 2/22/94; R 08/01/94]

SUBCHAPTER 1

GENERAL PROVISIONS

§17-1737-1 Purpose. This chapter shall set forth:

(1) Medical care and services provided to eligible persons under the fee for service component of the medical assistance program;
(2) Excluded services; and
(3) Conditions for payment.

[Eff 08/01/94] (Auth: HRS §346-14) (Imp: HRS §346-14)

§17-1737-2 Definitions. For the purpose of this chapter:

"Department" means the department of human services (DHS).

"Emergency" means a situation where a person's life or health is in imminent danger as the result of illness or injury and specialized services must be provided without delay.

"Emergency medical condition" means a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possess an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

(1) Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(2) Serious impairment to body functions; or
(3) Serious dysfunction of any bodily organ or part.

"Emergency services" means covered inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition that is found to exist using a prudent layperson standard.

"FFP" means federal financial participation.

"HCPCS" means the Health Care Financing Administration's (HCFA) Common Procedural Coding System.

"HMO" means a health maintenance organization providing a prepaid health plan to members such as the Kaiser foundation hospital, HMSA's community health program and health plan Hawaii.

"Health intervention" means an activity undertaken for the primary purpose of preventing, improving, or stabilizing a medical condition. Activities that are primarily custodial, or part of normal existence, or undertaken primarily for the convenience of the patient, family, or practitioner, are not considered health interventions.

"Health outcomes" means outcomes of medical conditions that directly affect the length or quality of a person's life.

"Informed consent" means a voluntary, knowing assent given in writing.

"Institutionalized individual" means an individual who is involuntarily confined or detained, under a civil or criminal statute, in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness; or confined, under a voluntary commitment, in a mental hospital or other facility for the care and treatment of mental illness.

"Law enforcement agency" means an agency charged under applicable law with enforcement of the general penal statutes of the United States or of any state or local jurisdiction.

"Long term care" means services provided to a recipient by a medical institution such as a skilled nursing facility, intermediate care facility, intermediate care facility for the mentally retarded, or any combination thereof.

"Medical condition" means a disease, an illness, or an injury. A biological or psychological condition that lies within the range of normal human variation is not considered a disease, illness, or injury.

"Medical necessity" refers to those procedures and services, as determined by the department, which are considered to be necessary and for which payment will be made. Medically necessary health interventions (services, procedures, drugs, supplies, and equipment) must be used for a medical condition. There shall be sufficient evidence to draw conclusions about the intervention's effects on health outcomes. The evidence shall demonstrate that the intervention can be expected to produce its intended effects on health outcomes. The intervention's beneficial effects on health outcomes shall outweigh its expected harmful effects. The intervention shall be the most cost-effective method available to address the medical condition. Sufficient evidence is provided when evidence is sufficient to draw conclusions, if it is peer-reviewed, is well-controlled, directly or indirectly relates the intervention to health outcomes, and is reproducible both within and outside of research settings.

"Medical pensioner" means a person receiving medical assistance under the medical payments for pensioner's program.

"Med-QUEST" means the division within the state department of human services which administers the medical assistance program.

"Program" means the medical assistance program (medicaid).

"Prudent layperson" refers to one who possesses an average knowledge of health and medicine.

"Prudent layperson standard" refers to the determination of a emergency medical condition based on the judgment of a prudent layperson.

"Public institution" means correctional facilities including, but not limited to, the prison and jail, and mental hospitals or facilities under the jurisdiction of a governmental unit.

"Respiratory therapist" means a person qualified to perform respiratory therapy as exemplified by certification by the national board for respiratory care (NBRC) or a person experienced in the performance of respiratory therapy services who is employed by a medicaid certified agency or provider to specifically provide respiratory therapy services.

"Respiratory therapy" means the performance of preventive, maintenance, and rehabilitative airway-related techniques and procedures including application of medical gasses, humidity, and aerosols, intermittent positive pressure, continuous artificial ventilation,

the administration of drugs through inhalation, patient care and instruction, and the provision of consultation to other health personnel.

"Stock" means articles in supply or on hand.

"Transportation" means payment for the cost of travel or transfer by taxicab, air and ground ambulance, out-of-state or inter-island airline to, from, or between medical facilities and other providers of health services.

"UCC" or "utilization control committee" means the committee that controls admissions and continued stay in acute hospital facilities based on the utilization control plan approved by the federal government for Hawaii's medical assistance program. [Eff 08/01/94; am 01/29/96; am 07/06/99] (Auth: HRS §346-14) (Imp: HRS §346-14)

SUBCHAPTER 2

INPATIENT AND OUTPATIENT HOSPITAL SERVICES, PHYSICIANS SERVICES

§17-1737-3 Inpatient hospital care. (a) Inpatient hospital care means services that are ordinarily furnished in a hospital for the care and treatment of inpatients under the direction of a physician, podiatrist, or dentist and which is furnished by an institution meeting the following requirements:

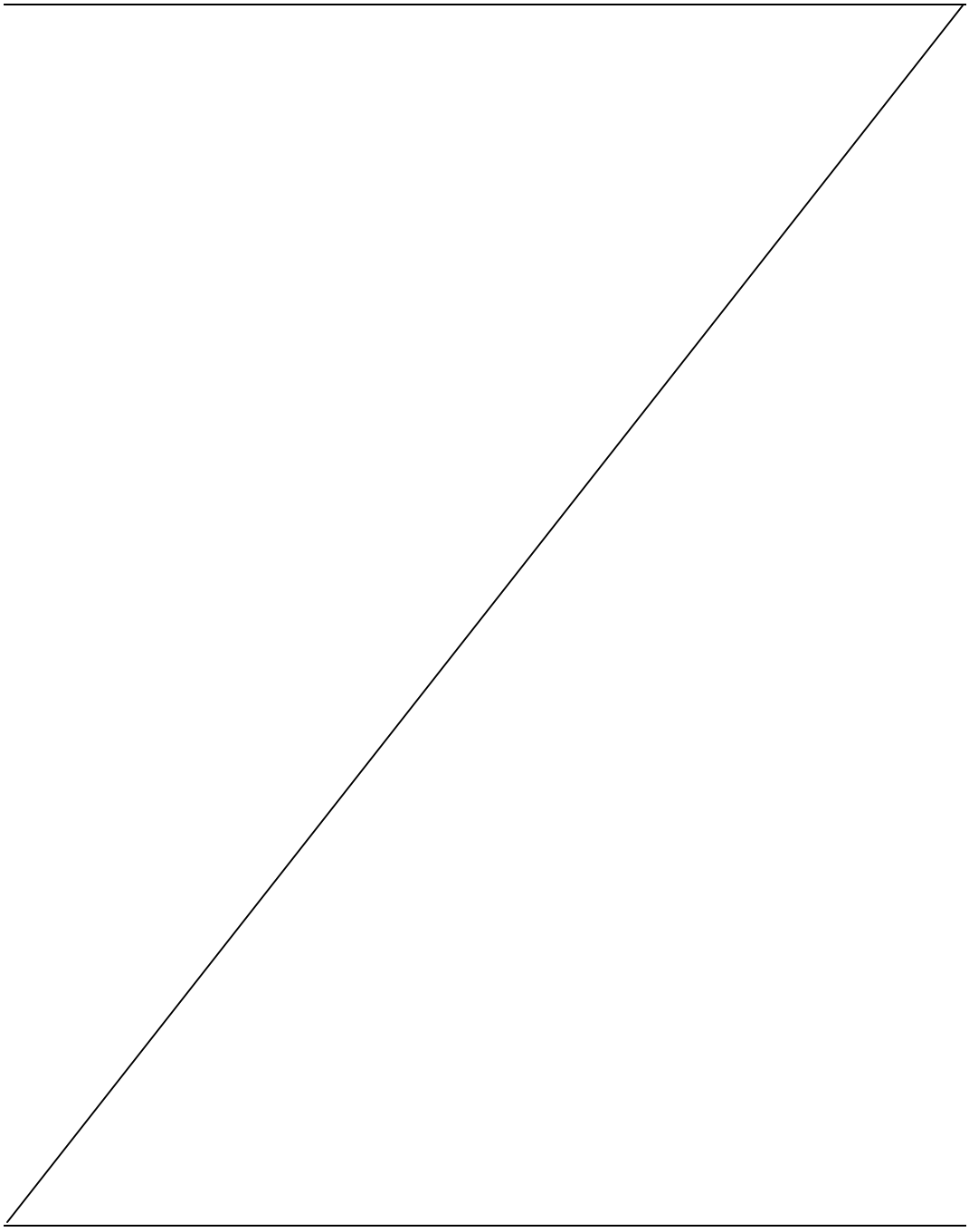
(1) Is not maintained primarily for the treatment of tuberculosis, mental diseases, or Hansen's disease;
(2) Is licensed as a hospital by the State;
(3) Meets the requirements for medicare participation; and
(4) Has in effect a utilization review plan approved by the department.

(b) Inpatient hospital care shall include the following:

(1) Ward or semiprivate accommodations including bed and meals, or a private room when medically indicated;
(2) Nursing care;
(3) Drugs, dressings, and diagnostic and therapeutic procedures as prescribed by the attending physician; and

(4) Other ancillary services associated with hospital care except private duty nursing.

(c) The department shall not pay for inpatient



hospital care in the following instances:

(1) Patients whose medical needs do not require admission for acute inpatient care;

(2) Diagnostic procedure which may be performed on an outpatient basis;

(3) Personal comfort items furnished by the hospital; and

(4) Partial hospitalization, day, evening, or night care, except for a patient receiving a surgical procedure or test which would permit return to the patient's home on the same day.[Eff 08/01/94] (Auth: HRS §346-14) (Imp: 42 C.F.R. §440.10)

§17-1737-4 Length of inpatient hospital care and extension of stay. (a) The UCC of an acute hospital facility shall determine the medical necessity for admission and continued stay for all recipients.

(b) The length of stay for the service category maternity after the delivery of a live newborn shall be limited to two days after delivery for a normal delivery and four days after delivery for a Cesarean section delivery. Stays exceeding these limitations must be authorized for medical necessity by the DHS's medical consultant or its authorized representative.

(c) A request for the extension of hospital stay shall be requested only when a patient is awaiting placement in a long term care facility. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: 42 C.F.R. §440.230)

§17-1737-5 Physician services. (a) Physician services means services provided within the scope of practice of medicine or osteopathy as defined by state law.

(b) Medicaid payments shall be made for medically necessary services when the services are provided by a physician authorized by the department at locations including, but not limited to:

(1) The physician's office;

(2) A clinic;

(3) A private home;

(4) An approved hospital;

(5) An approved skilled nursing or intermediate care facility; or

(6) A licensed care home or adult family boarding

home.

(c) For the purpose of this program, the following physicians' services shall be non-reimbursable:

(1) Hospital visits to a patient in an institution for tuberculosis, Hansen's disease, or mental disease; and

(2) Professional services rendered to an inmate of a public institution, including visits to a hospital where the inmate is confined temporarily. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: 42 C.F.R. §§440.50, 441.13)

§17-1737-6 Outpatient hospital services. Out-patient hospital services means preventive, diagnostic, therapeutic, rehabilitative, or palliative services provided to an outpatient by or under the direction of a physician or dentist and which are furnished by an institution meeting the following requirements:

(1) Is licensed or formally approved as a hospital by the State; and

(2) Meets the requirements for medicare participation. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: 42 C.F.R. §440.20)

§§17-1737-7 to 17-1737-10 (Reserved).

SUBCHAPTER 3

PSYCHIATRIC CARE

§17-1737-11 Definitions. For the purpose of this subchapter:

"Board to determine and certify mental disability" means a board of licensed psychologists or licensed physicians whose specialty is psychiatry designated and paid for by the department.

"Conjoint therapy" means treatment involving two family members only and shall be considered a form of individual therapy.

"Consultation" means an opinion or advice requested by a practicing physician from a psychiatrist or psychologist.

"Crisis intervention" means a process providing time limited services to reduce a stressful situation or help a patient deal with stress more effectively.

Designated provider" means a psychiatrist or a psychologist designated by the department to conduct examinations for mental impairment.

Direct supervision" means a psychiatrist shall be present and available in an inpatient facility or outpatient clinic to provide assistance and direction to non-physician therapists.

"Emergency psychiatric care" means immediate relief or help to a person who has decompensated in the face of internal or external stress and who is unable to cope with the situation.

"Family therapy" means treatment involving three or more members of the same family and shall be considered a form of group therapy.

"Group psychotherapy" means a method of psychotherapeutic treatment involving interaction between patients and therapist for purposes which otherwise may not be feasible in individual psychotherapy or other modalities of treatment. Groups shall consist of four to ten patients.

"Individual psychotherapy" means a face to face interaction between two parties, the therapist and the patient. The term encompasses a wide variety of therapies that differ in intensity and duration.

"Maintenance therapy" means psychiatric treatment of patients who do not require intensive psychiatric care, but who continue to require psychiatric medication and supportive care to maintain a functional state.

"Medical evaluation" means an evaluation by a physician to eliminate the possibility that the mental impairment is due to a physical illness.

"Physical illness" means medical conditions exclusive of those listed in the Diagnostic and Statistical Manual of Mental Disorders (Third Edition-Revised, DSM III R).

"Psychiatric care" means an established mode of practice offering the most effective and humane treatment for the acutely ill.

"Psychiatric evaluation" means a diagnostic interview of a patient that includes history, mental status, and a report of the findings of the interview.

"Psychiatric providers" means those individuals and facilities authorized to provide psychiatric services under the medicaid program.

"Psychiatric service" may be used interchangeably with "psychiatric care."

"Qualified clinical practitioner" means an authorized provider who maintains a private office and who cares for patients on a scheduled basis.

"Substance abuse" means excessive use of substances that alter or impair consciousness.

"Treatment" means the process of psychotherapy where disorders are treated on a time limited basis and where symptomatic relief of an immediate crisis is the primary objective. [Eff 08/01/94; am 09/14/98] (Auth: HRS §346-14) (Imp: 42 C.F.R. §§405.1011, 405.1020, 440.2, 440.50)

§17-1737-12 Authorized providers of psychiatric services. Individuals and facilities authorized to participate under the medicaid program shall meet the provisions of chapter 17-1736. In addition the authorized provider shall meet the following requirements:

(1) Psychiatrists shall be:
    (A) Licensed to practice in the state;
    (B) Have completed an approved three year residency training program or "Certified" by the American Board of Psychiatry and Neurology; and
    (C) In active clinical practice;
(2) Psychologists shall:
    (A) Be licensed to practice in the State;
    (B) Have earned a doctoral degree in clinical, educational, or counseling psychology; and
    (C) Be in active clinical practice;
(3) General hospitals with a separate license as a psychiatric facility under Hawaii Administrative Rules, Title XI, chapter 93, shall have:
    (A) Qualified professional, technical, and consultant personnel available to evaluate each patient at the time of admission;
    (B) Qualified, professional, technical, and supporting personnel to carry out an intensive and comprehensive treatment program;
    (C) A seclusion room;
    (D) Psychiatric services available at all times; and

(E) The capability to admit voluntary and involuntary commitments; and

(4) State community mental health centers and psychiatric outpatient clinics attached to a general hospital with a separate license as a psychiatric facility may provide psychiatric care through the centers' therapeutic teams. A therapeutic team shall:

(A) Be under the direct supervision of a psychiatrist; or

(B) For patients who are not prescribed medications, be under the supervision of a psychologist; and

(C) Provide care that meets the patient's specified needs. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 C.F.R. §§405.232(a), 440.60)

§17-1737-13 Psychiatric consultation. (a) A psychiatrist's or psychologist's consultation shall be for diagnostic evaluation and treatment planning of a patient.

(1) Consultation shall be limited to a total of two hours, in one or two visits, for interview and documentation.

(2) Prior authorization is not required.

(3) A copy of the report shall be provided to the department's medical or psychiatric consultant upon the department's request.

(b) Restrictions on psychiatric consultations are requests by:

(1) Friends;

(2) Relatives; or

(3) Other interested persons. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 C.F.R. §405.231)

§17-1737-14 Diagnostic and evaluative procedures for psychiatric care. (a) Psychological testing shall be authorized as a diagnostic or evaluative procedure.

(b) Prior authorization is required for all psychological testing except when given in an inpatient facility or when requested by the department's professional staff.

(1) The request for prior authorization shall be completed, signed, and dated by the psychiatrist or psychologist;
(2) The request for prior authorization shall be received in the medical assistance program (medicaid) office within five working days from the date of testing. The postmarked date shall be accepted provided it is within the five working days requirement;
(3) Reimbursement to the psychiatrist or psychologist shall be denied when forms are not received within the specified time.

(c) Authorization shall be for a maximum of six hours per twelve month period.

(d) The number of hours authorized includes time for interview, appraisal, and concluding documentation.

(e) Only time spent by a qualified psychiatrist or psychologist in administering, monitoring, and evaluating tests shall be reimbursable. Time spent by a technician is not reimbursable.

(f) A copy of the testing report shall be provided to the department's psychiatric or medical consultant upon request.

(g) Testing requested by the following agencies and individuals for their use shall not be authorized:
(1) Friends;
(2) Relatives; or
(3) Other interested persons.

(h) Evaluation to determine mental impairment for general assistance applicants and recipients between eighteen and sixty-five years of age shall be completed by designated providers. No prior authorization is required. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 C.F.R. §405.231)

§17-1737-15 REPEALED. [Eff 08/01/94; R 09/14/98] (Auth: HRS §346-14, 346-71; 42 C.F.R. §430.10) (Imp: 42 C.F.R. §405.231)

§17-1737-15.1 Examination for, determination, and certification of mental disability. (a) The department shall designate providers to conduct the mental examinations.
(1) Selection of the providers shall be based on the following:

(A) Past history of conducting and reporting on mental examinations that meet the department's standards.
(B) An understanding of the purpose, pertinent issues and potential problems of the new examination and the services that the department expects it to provide.
(C) Responsiveness and responsibility to assist the department in achieving its goals.

(b) For a determination and certification of mental disability, the department shall designate a board to determine and certify mental disability. The following shall apply to the board to determine and certify mental disability:

(1) The board shall consist of licensed physicians who are actively engaged in the practice of psychiatry in the State and a licensed psychologist actively engaged in the practice of psychology in the State; and
(2) The duties of the board shall be to determine and certify mental disability of applicants and recipients for general assistance.

[Eff 09/14/98] (Auth: HRS §§346-14, 346-71; 42 C.F.R. §430.10) (Imp: 42 C.F.R. §405.231)

§17-1737-16 Medical Evaluation. (a) Applicants who have been determined eligible for medicaid due to mental impairment shall be required to enter into outpatient treatment. They shall also be required to be medically evaluated by a physician to eliminate the possibility that their mental impairment is due to a physical illness.

(b) The medical evaluation may include and shall be limited to:

(1) History and physical examination;
(2) Complete blood count (CBC), urinalysis, and SMAC 20 or its equivalent; and
(3) Additional tests or further studies may be done if they are medically indicated. Justification for further studies shall be provided to the department's medical or

psychiatric consultant upon the department's request.

(c) The medical evaluation shall be completed no later than four weeks from the date of approved benefits. The result of the medical evaluation shall be submitted to the branch or unit requesting the information. The medical evaluation shall indicate whether the mental impairment was or was not due to a physical illness. [Eff 08/01/94] (Auth: HRS §364-14; 42 C.F.R. §430.10) (Imp: 42 C.F.R. §405.231)

§17-1737-17 Psychiatric service and treatment. (a) Psychiatric service shall be allowed where:

(1) It is provided under an individualized treatment or diagnostic plan which may be revised during treatment if necessary. Psychiatric service furnished without a planned program of therapy does not constitute treatment and is not reimbursable; and

(2) There is a reasonable expectation that service will improve the patient's condition. If the patient's condition is not altered after the authorized outpatient visits in the authorized period of treatment the frequency and number of subsequent outpatient visits requested may be reduced.

(b) A psychiatrist shall serve as a source of information and guidance when psychiatric service is provided by authorized mental health therapeutic teams;

(c) Drug management alone shall not be considered psychiatric care but shall be considered general medical care. Payments for drug management shall be made to:

(1) Authorized outpatient clinics for the cost of the drugs; or

(2) Psychiatrists at a general medical visit rate when accepting referrals for the purpose of prescribing psychiatric medications or evaluation of psychiatric medications.

(d) Psychiatric treatment shall be authorized for:

(1) Individual therapy, in a behavioral or analytic framework;

(2) New but non-experimental modes of therapy with prior authorization. The prior authorization will be granted if the provider can demonstrate adequate training and

experience in that particular mode of therapy;

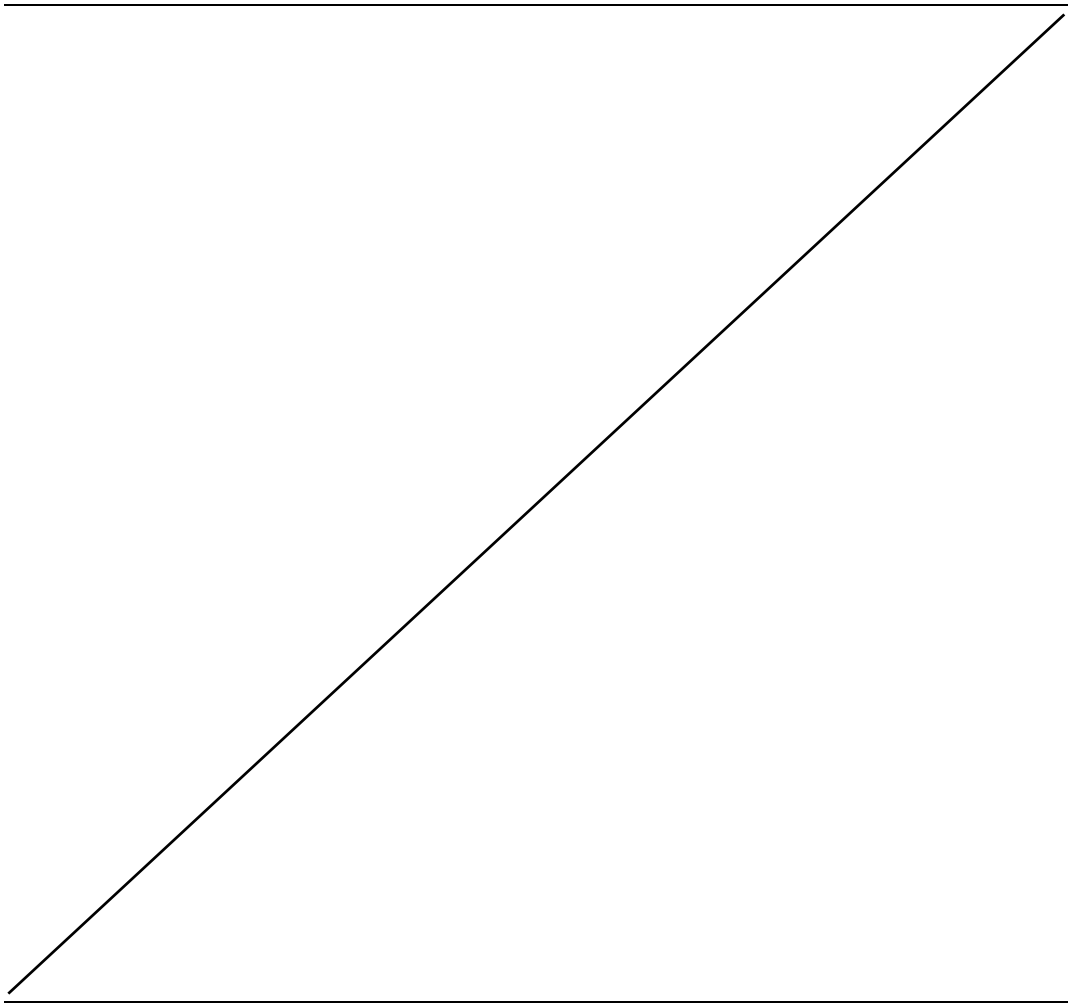
(3) Group therapy or its variant, including family therapy, which can provide dimensions of treatment not available by other modes of treatment;

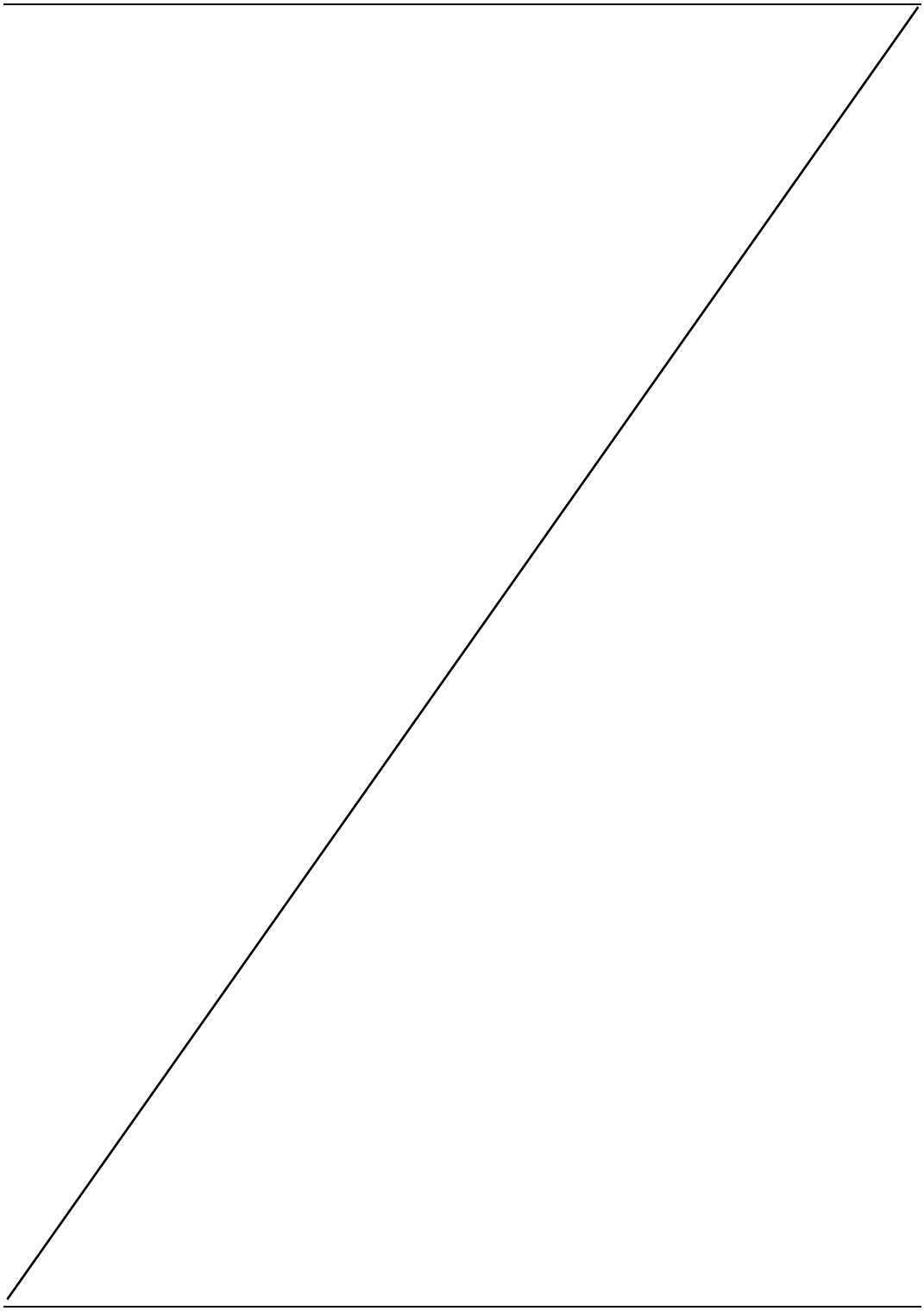
(4) Combined therapy, a combination of group and individual psychotherapy, except that:

(A) Visits shall be either for group or individual therapy, but not for both, on the same day;

(B) The patient may have different therapists for group and individual psychotherapy; but

(C) The involved therapists must be





co-jointly responsible for coordinating the care and treatment of the patient;

(5) Maintenance therapy, provided by physicians other than psychiatrists where:

(A) The physician shall prescribe psychiatric medication and observe the patient for any changes in the patient's condition or behavior;

(B) The physician shall provide supportive care, however, justification and prior authorization shall be required on the designated form requesting outpatient care if supportive care visits are made more frequently than monthly;

(C) Psychiatric consultation by a psychiatrist shall be readily available to the physician providing maintenance therapy; and

(D) Reimbursement for maintenance therapy shall be equivalent to that of a general medical office visit; and

(6) Patients with alcohol and drug problems may require monitoring by pertinent laboratory data. Such decisions regarding the monitoring of data will be decided after consultation and approval of the treating physician.

(c) Exclusions for psychiatric care and treatment are those for:

(1) Sex;

(2) Marriage;

(3) Diet;

(4) Employment counseling;

(5) Primal therapy;

(6) Long term character analysis;

(7) Marathon group therapy;

(8) Consortiums; and

(9) Other modalities as determined by the department. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 C.F.R. §405.231)

§17-1737-18 Inpatient psychiatric care. (a) Inpatient psychiatric care shall be provided only in an authorized psychiatric facility and by authorized psychiatric providers.

(b) Admission to a psychiatric facility shall be

by:

(1) A psychiatrist; or

(2) A non-psychiatrist physician with a psychiatrist concurring that admission is needed.

(c) Authorization for inpatient psychiatric care is required for:

(1) All application or pending cases; and

(2) Medicaid patients with third party coverage or any other available resources except for medicare.

(d) The department of human services form for medical authorization shall be used to request authorization for inpatient psychiatric care. The following procedures shall be taken:

(1) The form shall be completed by the inpatient psychiatric facility and shall be signed and dated by a psychiatrist or countersigned and dated by a psychiatrist when the patient is admitted by non-psychiatrist physician;

(2) The psychiatric facility and the physician shall both be responsible for submitting the form to the medical assistance program (medicaid) office;

(3) The form shall be received in the medical assistance program (medicaid) office of the department within five working days from the time of the patient's admission. The postmarked date shall be accepted provided it is within the five working days requirement from the time of patient's admission;

(4) Reimbursements to the physician and psychiatric facility is subject to denial when forms are not received within the specified time;

(5) A form shall be submitted for each admission; and

(6) An extension form will not be required regardless of length of stay.

(e) The length of hospital stay is applicable to all categories and the following shall be followed:

(1) No more than thirty days per calendar year shall be authorized. Inpatient days not used in the authorized calendar year shall not be added to the inpatient days allowed for the following calendar year;

(2) The number of inpatient days available through a third party coverage shall be

counted as part of the authorized number of days under Medicaid. The psychiatric facility shall apply the number of inpatient days that are available from the third party resource to the authorized number of days under Medicaid; and

(3) One inpatient day can be exchanged for two outpatient hours.

(f) Emergency inpatient psychiatric care shall be provided as follows:

(1) In communities where a psychiatric facility is not readily available, emergency inpatient psychiatric service may be provided for up to forty-eight hours at the closest licensed general hospital; and

(2) A patient shall be transferred to an authorized psychiatric facility or to a long-term psychiatric facility if the attending physician determines that the patient requires inpatient psychiatric service beyond the forty-eight hour period.

(g) Voluntary patients may obtain psychiatric inpatient hospital passes only as needed for discharge planning purposes. Involuntary patients will be regulated according to legal requirements.

(1) A patient is authorized eight hours to assist in his discharge preparation. The hours may be used in a flexible and judicious manner throughout the duration of admission.

(2) Exceptions may be made for patients who will benefit from program under the auspices of the treating hospital.

(3) All other types of hospital passes are not reimbursable. [Eff 08/01/94; am 06/19/00] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: HRS §431M-4; 42 C.F.R. §§440.10, 440.160)

§17-1737-19 Licensed general hospital. (a) A patient admitted to a licensed general hospital for a medical condition may be provided psychiatric care on the medical unit only when it is determined through psychiatric consultation that the patient's condition does not require the patient to be admitted to a psychiatric facility.

(1) A maximum of four visits for psychiatric care shall be allowed.

(2) Prior authorization shall be required through the designated outpatient request form if the patient requires more treatment than the authorized four hours. It shall be noted in the required form that the patient is in a licensed general hospital.

(b) Prior authorization is required to admit a patient to a psychiatric facility from a medical unit for all applications and pending cases.

(1) The appropriate department of human services form for prior medical authorization shall be used to request authorization for inpatient psychiatric care.

(2) All other appropriate policies for inpatient psychiatric care shall apply.

[Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §§431.10, 405.1020) (Imp: 42 C.F.R. §§405.116, 405.1020)

§17-1737-20 Inpatient care for substance abusers. (a) Prior authorization for medical pensioners plan cases are required for inpatient care for alcohol and non-alcohol substance abuse regardless of whether the patient is admitted to a medical unit of the hospital or to the psychiatric unit of the hospital.

(b) Inpatient care for alcohol substance abuse shall be as follows:

(1) Patients requiring only detoxification shall be referred to a detoxification facility for treatment;

(2) If a detoxification facility is not available, the attending physician may admit the patient to a licensed general hospital; and

(3) Patients requiring detoxification in addition to psychiatric or medical care shall be referred to an authorized inpatient psychiatric facility for psychiatric care or to a licensed general hospital for medical care.

(c) Inpatient care for non-alcohol substance abuse shall be as follows:

(1) Patients requiring only detoxification for substance abuse shall be referred by the attending physician to an appropriate facility for detoxification; and

(2) Patients requiring detoxification in addition to psychiatric or medical care shall be referred by the attending physician to an appropriate facility for treatment.

(d) Prior authorization shall not be required for the initial forty-eight hours of emergency care. If the attending physician determines that the patient requires further inpatient care the patient shall be transferred to an appropriate facility.

(e) Maximum hospital stay for patients requiring only detoxification shall be ten days.

(f) Hospital stay for patients requiring more than ten days for detoxification may be allowed provided that there is a justification that patient requires more than ten days for inpatient care. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §§431.10, 405.1020) (Imp: 42 C.F.R. §§405.116, 405.1020)

§17-1737-21 Outpatient psychiatric care. (a) Outpatient psychiatric care shall be provided by authorized psychiatric providers.

(b) Prior authorization is required for outpatient psychiatric care for:

(1) All eligible recipients in need of outpatient psychiatric care;

(2) Non-medicaid patients who become eligible for medical assistance and whose outpatient visits may be covered retroactively. The prior authorization form shall be submitted by the provider immediately upon learning that the patient became eligible for retroactive coverage; and

(3) Medicaid patients with third party coverage or any other available resources except for medicare.

(c) The appropriate department of human services form for prior medical authorization shall be used to request authorization for outpatient psychiatric care. The following procedure shall be taken:

(1) The form shall be completed, signed, and dated by the psychiatrist or psychologist;

(2) The form shall be received in the medical assistance program (medicaid) office of the department within five working days from the time of the patient's first visit. The postmarked date shall be accepted provided it

is within the five working days requirement from the time of patient's first visit;

(3) Subsequent requests shall be submitted to themedical assistance program (medicaid) office within five working days from the date of the last visit authorized. The postmarked date shall be accepted provided it is within the five working days requirement; and

(4) Reimbursements to the physician or psychologist shall be denied when forms are not received within the specified time.

(d) Outpatient visits for psychiatric care shall be as follows:

(1) Emergency room service in a licensed general hospital may be provided to patients with psychiatric problems. Services shall consist of examination for clinical impression and treatment; and

(2) Office or clinic visits shall be a face to face, personal contact between the patient and the authorized therapist for therapy or for a diagnostic purpose.

(e) Outpatient visits shall not be reimbursed for time spent beyond one hour for individual therapy; or two hours for group therapy.

(f) The number of visits shall be as follows:

(1) The maximum number of visits for the primary mode of therapy is twenty-four one hour individual visits or twenty-four one and one-half to two hour group visits within a twelve month period;

(2) For a combination of group and individual psychotherapy, the maximum for the primary modality is twenty-four visits and the maximum for the secondary modality (when twenty-four of the primary modality is approved) is six visits within a twelve month period;

(3) Any combination of group and individual psychotherapy is allowed, provided the total of thirty visits and the maximum for the primary modality are not exceeded;

(4) One-half hour (twenty to thirty minutes), or one quarter hour (ten to fifteen minutes), as well as one hour (forty-five to fifty minutes) individual psychotherapy visits are allowed. Any combination of visits is allowed, provided the total does not exceed

twenty-four one hour visits within a twelve month period; and

(5) One inpatient day can be exchanged for two outpatient hours.

(g) Approval of a second request and subsequent requests shall be based on the severity of the patient's illness.

(1) Severe cases shall be allowed a maximum of twenty-four visits within a twelve month period;

(2) Moderate cases shall be allowed a maximum of eighteen visits within a twelve month period;

(3) Maintenance cases shall be allowed a maximum of twelve visits within a twelve month period; and

(4) Personality disorders without acute crisis shall be eligible for extension after one year of treatment, with sufficient justification.

(h) Visits not used in the authorized twelve month period shall not be added to the outpatient visits allowed for the following twelve month period.

(i) A summary of the patient-therapist relationship may be requested at any interval after the onset of treatment:

(1) The summary should include such information as a justification for said diagnosis, a logical expressed treatment plan and observed changes since the onset of patient-therapist relationship; and

(2) The summary shall be utilized by the department's psychiatric consultant or by the department's established peer review committee to determine the number of subsequent out-patient visits that shall be authorized.

(j) Patients who have been under continuous psychiatric treatment for longer than a year may have their records reviewed by the department's psychiatric consultant for progress towards rehabilitation and general productivity of therapy before further outpatient visits are approved. If the provider is in disagreement with the department's psychiatric consultant's determination, the case shall be referred to the department's established peer review committee for review.

(k) Psychiatric outpatient visits available through third party coverage shall be counted as part of a patient's authorized visits under medicaid. It

shall be the provider's responsibility to apply the number of visits available from the third party coverage to the authorized number of visits under medicaid.

(l) Excluded from the psychiatric program are:

(1) Partial hospitalization, day, evening, and night care;

(2) Residential treatment centers;

(3) Skilled nursing facilities;

(4) Intermediate care facilities;

(5) Consortiums; and

(6) Home visits to a residence, care home, boarding home, or other living arrangement, except in an emergency situation.

[Eff 08/01/94; am] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 C.F.R. §440.20)

§§17-1737-22 to 17-1737-25 (Reserved).

SUBCHAPTER 4

LONG TERM INSTITUTIONAL SERVICES

§17-1737-26 Scope and purpose. (a) This subchapter governs the standard for payment which providers of long-term institutional services shall meet to qualify for medical payments for services provided to medicaid recipients.

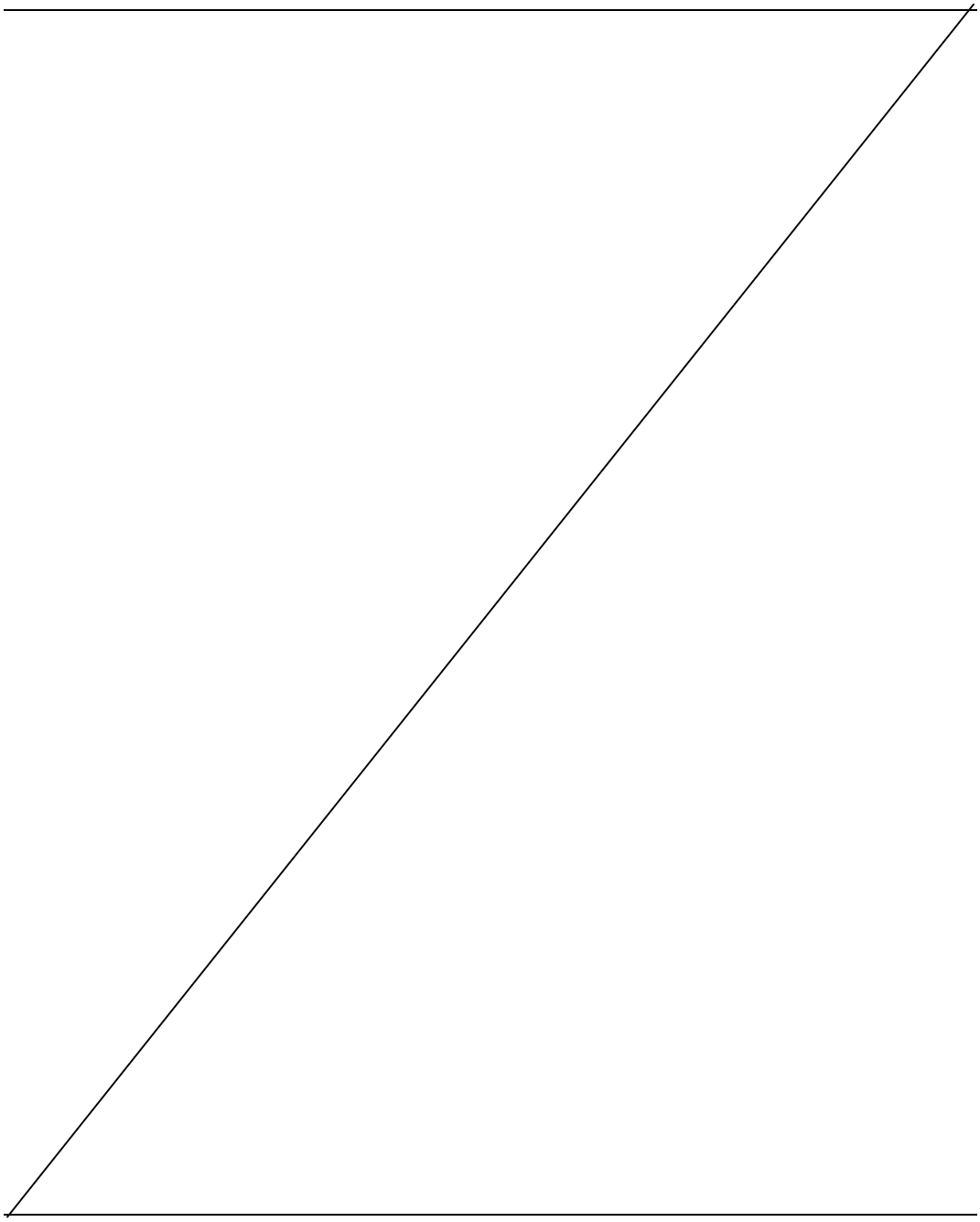
(b) This subchapter shall ensure provision of effective and appropriate long-term institutional services and the on-going evaluation of the quality, appropriateness and timeliness of such services to medicaid recipients. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §§430.10, 431.10; Pub. L. No. 100-203) (Imp: 42 C.F.R. §§440.40, 440.150, 440.260, 483.1)

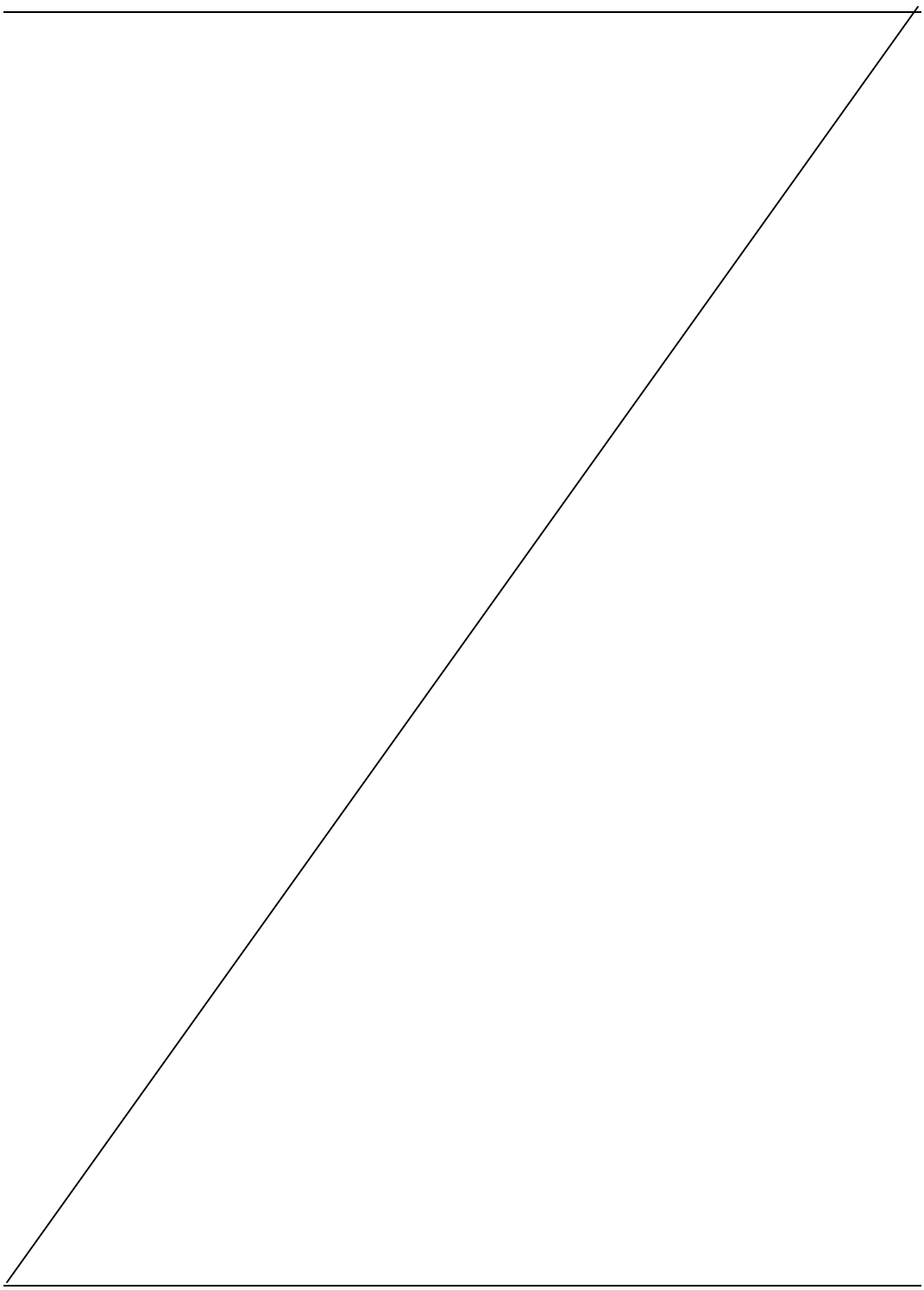
§17-1737-27 Definitions. For the purpose of this subchapter:

"Active treatment" is a continuous program for each client which includes aggressive, consistent implementation of a program of specialized and generic training, specific therapies or treatments, activities,

health services, and related services, as identified in an individualized plan of care:

(1) For individuals with "Mental Illness" (MI) the plan shall be developed under and supervised by a physician. The prescribed





components of the individualized active treatment program shall be provided by a physician or other qualified mental health professionals for the treatment of persons who are experiencing an acute episode of severe MI which necessitates twenty-four hour supervision by trained mental health personnel to diagnose or reduce the recipient's psychotic or neurotic symptoms which necessitated institutionalization, to improve the recipient's level of functioning and, whenever possible, to achieve the recipient's discharge from inpatient status at the earliest possible time;

(2) For individuals with "Mental Retardation or with related conditions" (MR), the individual program plan shall be developed and supervised by an interdisciplinary team that represents areas that are relevant to identifying the client's needs and to designing programs that meet the client's needs, and is directed towards:

(A) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and

(B) The prevention or deceleration of regression or loss of current optimal functional status. Active treatment does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program; and

(3) It does not include, in the case of a resident of a Nursing Facility (NF), services within the scope of services which the facility shall provide or arrange for its resident.

"Acuity level (or level of medical care)" means one of the following types of inpatient services: NF or ICF-MR.

"Applicant" means an individual whose written application for medicaid assistance has been submitted to the department but who has not received final action. The term includes an individual, who need not be alive at the time of application, but whose application is submitted through a representative or a

person acting responsibly for the deceased individual.

"Attending physician" means a medical doctor (M.D.) or a doctor of osteopathy (D.O.) who orders and directs the services required to meet the care needs of a medicaid recipient in a long-term institutional care facility. The attending physician may be a physician from a group practice who is designated as the primary physician or an alternate physician that has been delegated the role of the attending physician by the recipient's initial attending physician during the physician's absence.

"Clinical Nurse Specialist" means a registered professional nurse who is currently licensed to practice in the State and who meets one or two of the following conditions:

(1) Has completed an earned graduate degree - master's degree or doctorate - related to an advanced area of clinical practice within the scope of nursing; and

(2) Currently certified as a nurse specialist by a national nursing certifying organization.

"Dementia" refers to a primary diagnosis as described in the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition, Revised (DSM-III-R) with the following diagnostic criteria:

(1) Demonstrable evidence of impairment in short-term or long-term memory;

(2) At least one of the following:

(A) Impairment of abstract thinking;

(B) Impaired judgement;

(C) Other disturbances of higher cortical function; and

(D) Personality change;

(3) The disturbance in (1) or (2) significantly interferes with work or usual social activities or relationships with others;

(4) Not occurring exclusively during the course of delirium; and

(5) Either:

(A) Evidence from the history, physical examination, or laboratory tests, of a specific organic factor that is judged to be etiologically related to the disturbance; or

(B) In the absence of such evidence, an etiologic organic factor can be presumed if the disturbance cannot be accounted for by any nonorganic mental disorder.

"Distinct part" or "DP" means an identifiable bed, room, ward, or building of a parent medical institution that is located on the site of the parent medical institution.

"Facility" means an institution such as a nursing facility or an intermediate care facility for the mentally retarded or persons with related conditions (ICF-MR), that furnishes health care services to inpatients.

"Freestanding" means a medical institution that is not a part of a parent medical institution or a medical institution that is separated geographically from the parent medical institution.

"Furnish," "furnishes," or "furnished" means items and services provided by or arranged and paid for through contractual agreement which are under the direct supervision of a provider of long-term institutional services.

"Habilitation" means training or education provided to the recipient to enable the recipient to function better in society.

"ICF-MR" means an intermediate care facility for the mentally retarded or persons with related conditions.

"IDPE" means an interdisciplinary professional evaluation conducted by an interdisciplinary professional evaluation team which, at the minimum, consists of complete medical, social, and psychological evaluations and diagnosis.

"Inpatient" means a patient who has been admitted to a medical institution on recommendation of a physician and who is receiving room, board, and professional services in the NF or an ICF-MR, on a continuous twenty-four hours a day basis.

"Institution" or "institutional facility" means an establishment that furnishes food, shelter, and some treatment or services to four or more individuals unrelated to the individual who has, directly or indirectly, an ownership interest of five per cent or more.

"Licensed health professional" means a physician, physician assistant, nurse practitioner, physical, speech or occupational therapist, registered professional nurse, licensed practical nurse, or licensed or certified social worker.

"Long-term institutional services" means services provided to a recipient by a medical institution such as a nursing facility or intermediate care facility for

the mentally retarded.

"Medical institution" means an institution that:

(1) Is organized to provide medical care, including nursing and convalescent care;

(2) Has the necessary professional personnel, equipment, and facilities to manage the medical, nursing, and other health needs of patients on a continuing basis in accordance with accepted standards;

(3) Is authorized under state law to provide medical care; and

(4) Is staffed by professional personnel who are responsible to the institution for professional medical and nursing services. The services shall include adequate and continual medical care and supervision by a physician, registered nurse supervision, and services sufficient to meet nursing care needs.

"Mental illness" refers to a current primary or secondary diagnosis of a mental disorder as defined in the Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition, Revised and does not have a primary diagnosis of dementia (including Alzheimer's disease or a related disorder).

"Mental retardation" refers to significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period:

(1) "General intellectual functioning" is defined as the results obtained by assessment with one or more of the individually administered general intelligence tests developed for the purpose of assessing intellectual functioning;

(2) "Significantly subaverage intellectual functioning" is defined as approximately IQ seventy or below;

(3) "Adaptive behavior" is defined as the effectiveness or degree with which individuals meet the standards of personal independence and social responsibility expected for age and cultural group; and

(4) "Developmental period" is defined as the period of time between birth and the eighteenth birthday.

"Nurse aide" means any individual providing nursing or nursing-related services to residents in a

nursing facility but does not include an individual:

(1) Who is a licensed health professional; or

(2) Who volunteers to provide such services without monetary compensation.

"Nurse practitioner" means a registered professional nurse who is currently licensed to practice in the state, and who meets one of the following conditions for practice in a NF or ICF-MR:

(1) Is currently certified as a gerontological nurse practitioner by the American Nurses' Association; or

(2) Has satisfactorily completed a formal one academic year educational program that:

(A) Prepares registered nurses to perform an expanded role in the delivery of care in the field of gerontology or mental retardation, whichever is appropriate;

(B) Includes at least four months (in the aggregate) of classroom instruction and a component of supervised clinical practice; and

(C) Awards a degree, diploma, or certificate to persons who successfully complete the program; or

(3) Has successfully completed a formal educational program (for preparing registered nurses to perform an expanded role in the delivery of care in the field of gerontology or mental retardation, whichever is appropriate) that does not meet the above requirements of (2) of this definition, and has been functioning in an expanded role in the delivery of care in the respective fields of gerontology or mental retardation for a total of twelve months during the eighteen month period immediately preceding the effective date of appointment as a nurse practitioner by the facility administrator.

"Nursing facility" means a free-standing or a distinct part of a facility that is licensed and certified as meeting the requirements of participation to provide skilled nursing, health-related care and rehabilitative services on a regular basis in an inpatient facility.

"Patient" means an applicant or recipient receiving needed professional services directed by the attending physician toward the maintenance, improvement, or protection of health, or lessening of

illness, disability, or pain.

"Persons with related conditions, such as epilepsy, cerebral palsy, or other developmental disabilities" are individuals who have a severe, chronic disability that meets all of the following conditions:

(1) It is attributable to a mental or physical impairment or combination of mental and physical impairments;
(2) It is manifested before the person reaches age twenty-two;
(3) It is likely to continue indefinitely;
(4) It results in substantial functional limitations in three or more of the following areas of major live activity:
    (A) Self-care;
    (B) Understanding and use of language;
    (C) Learning;
    (D) Mobility;
    (E) Self-direction;
    (F) Capacity for independent living; or
    (G) Economic self sufficiency; and
(5) Reflects the person's need for a combination and sequence of special interdisciplinary or generic care treatment or other services which are individually planned and coordinated.

"Physician assistant" means a person who is currently approved and certified as a physician assistant by the state board of medical examiners, state department of regulatory agencies.

"Provider" means NF or ICF-MR facilities that furnish long-term institutional services on an inpatient basis to recipients under a provider agreement with the department.

"QMRP" means a qualified mental retardation professional who has at least one year of experience working directly with persons with mental retardation or related conditions; and is one of the following:

(1) A doctor of medicine or osteopathy;
(2) A registered nurse; or
(3) An individual who holds at least a bachelor's degree in a professional category.

"Recipient" means an individual who has been determined eligible for medicaid assistance.

"Representative" means a resident's legal guardian, conservator, or representative payee as designated by the Social Security Administration, or

person designated in writing by the resident to manage his or her own personal funds.

"Resident" means a recipient who resides in a nursing facility and receives needed professional services directed by the attending physician toward the maintenance, improvement, or protection of health, or lessening of illness, disability, or pain.

"State mental health authority" means the adult mental health division of the department of health.

"State mental retardation/developmental disability authority" means the developmental disabilities division of the department of health.

"UR" means utilization review of inpatient long-term institutional services provided to recipients in an ICF-MR to determine whether continued stay at the specific level of care is appropriate.

"URC" means the utilization review committee, which is a group composed of one or more physicians and other health care professionals that conducts utilization review. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §§430.10, 431.10, 435.1009; Pub. L. No. 100-203) (Imp: 42 C.F.R. §§440.40, 440.150, 481.2, 435.1009; 42 U.S.C. §§1396, 6001 - 6008; Pub. L. No. 100-203)

§17-1737-28 Eligibility requirements. (a) The individual applicant shall meet the basic eligibility requirements of the medicaid program in order to qualify for medicaid assistance.

(b) Long-term institutional services shall be available to recipients who have been approved by the department to receive these services.
[Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §§430.10, 431.10, 442.1) (Imp: 42 C.F.R. §§431.10, 442.1)

§17-1737-29 Content of NF services. (a) Long-term institutional services shall be provided by free-standing or distinct part NFs that shall meet the eligibility requirements specified in chapters 17-1736 and 17-1739.

(b) NFs shall provide:

(1) Skilled nursing care and related services for residents who require medical or nursing care;

(2) Rehabilitation services for the

rehabilitation of injured, disabled, or sick persons; or

(3) On a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities, and is not primarily for the care and treatment of mental diseases.

(c) NF services shall be provided either directly by or under the general supervision of licensed practical nurses or registered professional nurses.

(d) NF services shall include, but shall not be limited to:

(1) Room and board;

(2) Administration of medication and treatment;

(3) Development, management, and evaluation of the written resident care plan based on physician orders that necessitate the involvement of skilled technical or professional personnel to meet the resident's care needs, promote recovery, and ensure the resident's health and safety;

(4) Observation and assessment of the resident's unstable condition that requires the skills and knowledge of skilled technical or professional personnel to identify and evaluate the resident's need for possible medical intervention, modification of treatment, or both, to stabilize the resident's condition;

(5) Health education services provided by skilled technical or professional personnel to teach the recipient self care, such as gait training and self administration of medications;

(6) Provision of therapeutic diet and dietary supplement as ordered by the attending physician;

(7) Laundry service, including items of recipient's washable personal clothing;

(8) Basic nursing and treatment supplies, such as soap, skin lotion, alcohol, powder, applicator, tongue depressor, cotton ball, gauze, adhesive tape, bandaid, incontinent pad, V-pad, thermometer, blood pressure apparatus, plastic or rubber sheet, enema

equipment, and douche equipment;

(9) Durable medical equipment and supplies used by residents but which are reusable, such as ice bag, hot water bottle, urinal, bedpan, commode, cane, crutch, walker, wheelchair, and siderail and traction equipment;

(10) Activities of the resident's choice (including religious activities) that are designed to provide normal pursuits for physical and psychosocial well-being;

(11) Social services provided by qualified personnel;

(12) Nonrestorative/nonrehabilitative therapy provided by nursing staff; and

(13) Provision of and payment for, through contractual agreements with appropriate skilled technical or professional personnel, other medical and remedial services ordered by the attending physician which are not regularly provided by the provider. Other services that may be needed, such as transportation to realize the provision of services ordered by the attending physician, shall also be arranged through contractual agreements. The contractual agreement shall stipulate the responsibilities, functions, objectives, service fee, and other terms agreed to by the NF and the person or entity that contracts to provide the service.

[Eff 08/01/94; am 02/10/97] (Auth: HRS §346-14; Pub. L. No. 100-203; 42 C.F.R. §§430.10, 431.10, 483.1) (Imp: Pub. L. No. 100-203; 42 C.F.R. §§440.40, 440.150, 483.1, 483.20, 483.28 - 483.30)

§17-1737-30 Content of ICF-MR services. (a) Long-term institutional services shall be provided by freestanding or distinct part ICF-MR facilities that shall meet the eligibility requirements specified in chapters 17-1736 and 17-1739.

(b) ICF-MR facilities shall provide inpatient or authorized community-based services designed primarily for the treatment and rehabilitation of the mentally retarded or persons with related conditions.

(c) ICF-MR services shall include but not be limited to:

(1) Twenty-four hour supervision of mentally

retarded individuals or persons with related conditions in a protected residential setting;

(2) A continuous active treatment program which includes aggressive, consistent implementation of a program of specialized and generic training, treatment health services and related services described in this subsection, that is directed towards:

(A) The acquisition of the behaviors necessary for the client to function with as much self-determination and independence as possible; and

(B) The prevention or deceleration of regression or loss of current optimal functional status.

Active treatment does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program;

(3) Interventions to manage inappropriate client behavior that are employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected;

(4) Sufficient direct care staff to manage and supervise clients in accordance with their individual program plans, to respond to injuries and symptom of illness and to handle emergencies in each defined residential living unit;

(5) Preventive and general medical care as well as annual physical exams of each client that include:

(A) Evaluation of vision and hearing;

(B) Immunizations, using as a guide the recommendations of the Public Health Service Advisory Committee on Immunization Practices or of the Committee on the Control of Infectious Diseases of the American Academy of Pediatrics;

(C) Routine screening lab exams and special studies; and

(D) TB control, appropriate to the facility's population, and in accordance with the recommendations of the American

College of Chest Physicians or the section of diseases of the American Academy of Pediatrics, or both;

(6) Licensed nursing services sufficient to care for clients health needs, including those clients with medical care plans;

(7) Provision of or arrangements for comprehensive dental diagnostic services and comprehensive dental treatment services that include:

(A) The availability of emergency dental treatment on a twenty-four hours a day basis by a licensed dentist; and

(B) Dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health;

(8) Provision of or arrangements for routine and emergency drugs and biologicals that are administered in compliance with physician's orders;

(9) At least three meals a day that comprise a nourishing, well-balanced diet including modified and specially prescribed diets;

(10) Physician services available twenty-four hours a day to:

(A) Develop and maintain, in coordination with licensed nursing personnel, a medical care plan of treatment for a client if the physician determines that an individual client requires twenty-four hours licensed nursing care; and

(B) Participate in establishing an initial individual program plan for a newly admitted client; and

(11) Provision of necessary services, including emergency and other health care through contractual agreements which shall:

(A) Stipulate the responsibilities, functions, objectives, service fee, and other terms agreed to by the ICF-MR and the provider; and

(B) Provide that the ICF-MR is responsible for assuring that the outside services meet the standards for quality of services. [Eff 08/01/94; am 02/10/97] (Auth: HRS §346-14; Pub. L. No. 100-203; 42 C.F.R.

§§430.10, 431.10, 483.400) (Imp: Pub. L. No. 100-203; 42 C.F.R. §§483.400 - 483.480)

§17-1737-31 Determining the applicant's or recipient's need for long-term institutional services. (a) The provision for the determination of need for admission to a long-term institution are based on a physician's and other appropriate health care professional's assessment of the applicant's or recipient's condition and recommendation of the applicant's or recipient's need for a specific acuity level (or level of medical care).

(b) Their recommendation of the applicant's or recipient's need for a specific acuity level (or level of medical care) shall be based on the following criteria:

(1) Acuity Level A recipient requires licensed nursing and ancillary nursing personnel services on a regular and long-term basis to maintain, improve, or safeguard health, or to minimize disability or pain. The services provided shall be beyond room, board, and personal care services available in personal care home, and shall:
   (A) Be available to recipients who require assistance with the normal activities of daily living twenty-four hours a day;
   (B) Be ordered by a physician and shall be provided under the direction of the attending physician or staff physician;
   (C) Be planned, provided, and maintained by licensed and ancillary nursing personnel and other professional personnel, in accordance with a written resident care plan;
   (D) Be provided on an inpatient basis only after consideration of the recipient's condition and the feasibility and availability of utilizing more economical alternative facilities and services have been ruled out; and
   (E) Be less than twenty-four hours of skilled nursing or regular rehabilitation services;
(2) Acuity Level B recipient shall:
   (A) Be evaluated by an interdisciplinary

professional team, who shall recommend admission based on their evaluation, which shall be completed not more than three months prior to admission, or before the ICF-MR requests payment for a client applying for medicaid after admission;

(B) Be diagnosed as mentally retarded or with other related conditions; and

(C) Require the medical care and special services that are appropriately obtained from an ICF-MR as described in section 17-1737-30; and

(3) Acuity Level C recipient requires skilled nursing services provided directly or under the general supervision of registered professional nurses on a twenty-four hour basis, rehabilitation services, or both and shall:

(A) Be provided on a seven-days a week basis, except rehabilitation services may be needed by the recipient and provided on a five-days a week basis; and

(B) Include subparagraphs (1)(A),(B),(C), and (D). [Eff 08/01/94] (Auth: HRS §§346-14, 346-49; Pub. L. No. 100-203; 42 C.F.R. §§430.10, 431.10) (Imp: Pub. L. No. 100-203; 42 C.F.R. §§435.1009, 440.40, 440.150, 456.270, 456.271, 456.370, 483.30, 483.440)

§17-1737-32 Authorization for admission to a NF or ICF-MR. (a) Authorization by the department for the recommended acuity level (or level of medical care) required by an applicant or recipient shall be in accordance with the provisions of chapter 1739 and section 17-1737-31.

(b) Authorization granted by the department for admission to a NF or ICF-MR shall be based on the determination that the applicant or recipient requires the services stipulated in sections 17-1737-29 and 17-1737-30. [Eff 08/01/94; am 02/10/97] (Auth: HRS §§346-14, 346-49; 42 C.F.R. §§430.10, 431.10, 435.1009) (Imp: 42 C.F.R. §§435.1009, 440.150, 456.271, 456.370, 483.440)

§17-1737-33 Preadmission screening and annual resident review (PASARR). The state (PASARR) program shall require that:

(1) NFs shall not admit, on or after January 1, 1989, any new resident with:

(A) "Mental illness" as defined in section 17-1737-27 unless the state mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the state mental health authority, prior to admission, whether:

(i) Because of the physical and mental condition of the individual, the individual requires the level of services provided by a NF; and

(ii) If the individual requires such level of services, the individual requires active treatment for mental illness; or

(B) "Mental retardation" or "persons with related conditions" as defined in section 17-1737-27 unless the state mental retardation/developmental disability authority has determined prior to admission whether:

(i) Because of the physical and mental condition of the individual, the individual requires the level of services provided by a NF; and

(ii) If the individual requires such level of services, the individual requires active treatment for mental retardation;

(2) For those residents who entered the NF prior to January 1, 1989, and were identified with a diagnosis of:

(A) "Mental illness" as defined in section 17-1737-27, the state mental health authority shall determine whether, because of the resident's physical and mental condition, the resident requires:

(i) The level of services provided by a NF; and

(ii) Active treatment for mental illness; or

(B) "Mental retardation" or identified as

"persons with related conditions" as defined in section 17-1737-27, the state mental retardation/developmental disability authority shall determine whether because of the resident's physical and mental condition, the resident requires:

(i) The level of services provided by a NF; and

(ii) Active treatment for mental retardation or related conditions in an ICF-MR;

(3) The frequency of review and determination shall be conducted for each resident of a NF who has mental illness or mental retardation not less often than annually. To the maximum extent practicable, in order to avoid duplicative testing and effort, the PASARR shall be coordinated with the annual resident assessments; and

(4) The first set of annual reviews and determinations on residents who entered the NF prior to January 1, 1989 shall be completed by April 1, 1990. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §§430.10, 431.10; Pub. L. No. 100-203) (Imp: Pub. L. No. 100-203; 42 C.F.R. §483.20)

§17-1737-34 Utilization control for NFs. (a) This section defines the utilization control process which shall be administered in accordance with state and federal regulations to achieve optimal quality control of the utilization of services provided under the state plan.

(b) The provisions for utilization control are as follows:

(1) Providers of NF services shall admit only those recipients whose health care needs may be met by the facility;

(2) Each resident shall receive the necessary nursing, medical and psychosocial services to attain and maintain the highest possible mental and physical functional status, as defined by the comprehensive resident assessment and plan of care;

(3) The NF shall operate and provide services in

compliance with all state, federal, and local laws, regulations, and codes and with accepted professional standards and principles that apply to professionals providing services in the NF;

(4) The services provided by or arranged by the NF shall meet professional standards of quality and be provided by qualified persons in accordance with each resident's written plan of care;

(5) The following requirements regarding nurse aides shall be met:

(A) A nursing facility shall not use any individual working in the facility as a nurse aide for more than four months unless the individual:

(i) Has completed a training and competency evaluation program or a competency evaluation program approved by the State; and

(ii) Is competent to provide such services;

(B) A nursing facility shall provide for individuals used as nurse aides a competency evaluation program approved by the State and such preparation as may be necessary to complete such a program;

(C) A nursing facility shall not permit an individual, other than in a training and competency evaluation program or a competency evaluation program approved by the State, to serve as a nurse aide or provider services of a type for which the individual has not demonstrated competency and shall not use such an individual as a nurse aide unless the facility has inquired of the state registry as to information in the registry concerning the individual;

(D) A nursing facility shall not use any individual as a nurse aide if there has not been a continuous period of twenty-four consecutive months during none of which the individual performed nursing or nursing-related services for monetary compensation, such individual

will need to complete a new training and competency evaluation program;

(E) A nursing facility shall provide regular performance reviews and regular in-service education to assure that individuals used as nurse aides are competent to perform services as nurse aides, including training for individuals providing nursing and nursing-related services to residents with cognitive impairments;

(F) Any findings of abuse or neglect of residents or misappropriations of residents' property by nurse aides shall be reported to the state department of health; and

(G) The state shall:

(i) Establish and maintain a registry of all individuals who have satisfactorily completed a nurse aide training and competency evaluation program or a nurse aide competency evaluation program approved by the State;

(ii) The registry shall include specific documented findings by the state of resident neglect or abuse or misappropriation of resident property as well as any brief statement of the individual disputing the findings; and

(iii) When inquiries to the registry are made concerning an individual listed in the registry, any information disclosed concerning such a finding shall also include disclosure of any such statement in the registry relating to the finding or a clear and accurate summary of such a statement; and

(6) Annual resident reviews as part of the PASARR program are required of residents who fall into either of two groups:

(A) All who were previously identified as having MI or MR through preadmission screening of initial reviews and who were permitted to enter or remain in the

facility; and

(B) Any other resident who are later discovered to have MI or MR or develops a new condition or a significant worsening of an existing condition should trigger an immediate evaluation of the resident and a referral to the mental health or mental retardation authority for a determination.

[Eff 08/01/94] (Auth: HRS §346-14; 42 U.S.C. §§1395, 1396; Pub. L. No. 100-203; 42 C.F.R. §§431.10, 435.1009, 456.1, 483.1) (Imp: Pub. L. No. 100-203; 42 C.F.R. §§435.1009, 442.1, 456.1, 456.250, 483.1, 483.20, 483.25, 483.75)

§17-1737-35 Utilization control for ICF-MRs. (a) This section defines the utilization control process which shall be administered in accordance with state and federal regulations to achieve optimal quality control of the utilization of services provided under the state plan.

(b) The provisions for the utilization control for ICF-MRs are as follows:

(1) A written certification or recertification statement that the client require a specific level of care is required as follows:

(A) Admission certification shall be provided by a physician or a nurse practitioner or a clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician, on admission or not more than sixty days prior to authorization of medicaid payment for the provision of long-term institutional services to the client;

(B) A recertification statement shall be provided by a physician or a physician assistant under the supervision of a physician or a nurse practitioner or a clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician, no more than twelve months following certification and thereafter no more

than twelve months intervals until discharge from the ICF-MR;

(C) The written certification and recertification statements shall be placed on a form designed either by the facility or the department specifically for certification and recertification documentations, and said form shall be placed in each client's active medical record; and

(D) The written certification and recertification statements shall clearly indicate the client's need for a specific level of care, and shall include:

(i) A physician's signature or initials clearly identified with the acronym "M.D." for medical doctor, or "D.O." for doctor of osteopathy;

(ii) A physician assistant's signature or initials, clearly identified with the acronym "P.A." for physician assistant;

(iii) A nurse practitioner's signature or initials, clearly identified with the acronym "R.N.C."or "R.N." whichever is appropriate; or

(iv) A clinical nurse specialist's signature or initials clearly identified with the acronym "R.N.M.S." or "R.N.C.S." whichever is appropriate; and

(v) The date of certification or recertification statement is signed or initialed by a physician or a physician assistant or a nurse practitioner or a clinical nurse specialist;

(2) The facility shall have in effect a written utilization review plan approved by the department which shall include the following methods and procedures:

(A) Use of cross reference file numbers in all UR related documentation to assure the anonymity of the medicaid client;

(B) Identification of the administrative entity and sub-group of the entity

responsible for the performance of UR and the medical staff of a medical institution;

(C) Development and selection and adoption of forms utilized for the UR process;

(D) Review of documentation necessary to verify justification for continued stay cases. The information shall be an integral part of the client's medical record and shall include the following:

(i) Name of the attending physician;

(ii) Date of admission to the facility;

(iii) Date of application if made after admission to the facility;

(iv) The written plan of care;

(v) The reasons for and the plan for continued stay when deemed necessary by the attending physician; and

(vi) As necessary, other documented material to support the utilization review committee's decision;

(E) Utilization review committee members shall not be involved in the care of a client whose case is being reviewed and shall not be employed by, or have a financial interest in any facility in which the URC functions;

(F) URC members must include at least one physician and one other professional responsible for review of continued stay cases and at least one member shall be a QMRP;

(G) Development and adoption of inhouse criteria by which continued stay cases shall be reviewed at least once in a six month period;

(H) Review by a physician member of the URC of cases not meeting the applicable inhouse ICF-MR criteria for continued stay; and

(I) Notification of continued stay denial to the affected client shall be as follows:

(i) The client's QMRP shall be notified within one working day, and an allowance of two working days shall be afforded to the QMRP to respond to the URC's continued stay denial

before it becomes final; and

(ii) Written notification of continued stay denial by the URC within two working days after the final URC determination shall be given to the facility administrator, the client, and the client's next of kin; and

(3) The facility shall operate and provide services in compliance with all state, federal and local laws, regulations, and codes and with accepted professional standards and principles that apply to professionals providing services in the facility. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §§430.10, 431.10, 456.1, 483.410; 42 U.S.C. §§1395, 1396) (Imp: 42 C.F.R. §§456.350, 456.351, 456.360, 456.370, 456.380, 456.381, 456.400, 456.401, 456.405 - 456.407, 456.411 - 456.413, 456.431 - 456.438)

§17-1737-36 Inspection of care (IOC) reviews in ICF-MR facilities. The department shall be responsible for conducting periodic inspection of care review in ICF-MRs to evaluate the utilization of care and services provided to the client:

(1) Inspection of care team members shall be employees of the department, and may consist of a physician or a registered nurse, and a social worker. One of the team members shall be a QMRP. If a physician is not on the team, a physician shall be available to provide consultation to the team;

(2) Frequency of inspection shall be based on the quality of care and services provided by the facility, and on the condition of clients in the facility. However, at the minimum, each client shall be evaluated once annually;

(3) No facility shall be notified of the time of inspection more than forty-eight hours before the scheduled arrival of the team;

(4) Method of inspection shall be by personal contact with and observation of each client, and review of each client's medical record to determine the following:

(A) Whether the facility services are adequate to meet the health needs of

each client, the rehabilitative and social needs of each client and to promote maximum physical, mental, and psychosocial functioning;

(B) Whether continued stay in the facility is necessary and desirable;

(C) Whether it is feasible to meet the client's health needs, and in an ICF-MR the client's rehabilitative needs through alternative institutional or noninstitutional services; and

(D) Whether each client is receiving active treatment in accordance with the provisions of section 17-1737-30;

(5) The determinations on adequacy of services and related matters stipulated in paragraph (4) shall be based on, but not limited to, such items as whether:

(A) The medical evaluation, any required social and psychological evaluations, and the Individual Program Plans, where required, are followed; and all ordered services, including dietary orders, are provided and properly recorded;

(B) The attending physician reviews prescribed medications at least quarterly;

(C) Tests or observations of each client indicated by his medication regimen are made at appropriate times and are properly recorded;

(D) The individual program plan must be reviewed at least every ninety days by the QMRP and revised as necessary;

(E) For those clients certified as not needing a medical care plan, a review of their health status must be a direct physical examination by a licensed nurse on a quarterly or more frequent basis depending on client need and the result of any action (including referral to a physician to address client health problems) shall be recorded in the client's record;

(F) Progress notes by physicians, nurses, social workers, and other professionals are made as indicated and are reflective of the need for the specific

professional's intervention consistent with the observed condition of the client, and support the need for continued stay at the ICF-MR;

(G) Progress notes shall be dated and signed followed by the professional's professional acronym;

(H) The client receives adequate services, based on such observations as cleanliness, absence of bedsores, absence of signs of malnutrition or dehydration, and apparent maintenance of maximum physical, mental, and psychosocial function;

(I) The client receives active treatment as defined in section 17-1737-30;

(J) The client needs any service that is not furnished by the facility through arrangements with others; and

(K) The client needs continued placement in the facility or there is an appropriate plan to transfer the patient to an alternate method of care;

(6) The inspection of care team shall prepare a report promptly after each inspection. The report shall contain:

(A) The observations, conclusions, and recommendations of the team concerning the adequacy, appropriateness, and quality of all services provided in the facility or through other arrangements, including physician services to client's, and specific findings about individual clients in the facility; and

(B) The dates of the inspection and the names and qualifications of the members of the team; and

(7) The department shall send a copy of each inspection report to the facility inspected, the facility's utilization review committee, and the state department of health.

[Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §§430.10, 431.10) (Imp: 42 C.F.R. §§456.600 - 456.613)

§17-1737-37 Other service requirements. (a) Providers of long-term institutional services shall

establish and implement written policies and procedures that govern access to, duplication of, and dissemination of information from applicants' or recipients' records:

(1) The following information about applicants and recipients shall not be released:
  (A) Names and addresses;
  (B) Eligibility status, the amount of assistance, or both;
  (C) Medical services provided;
  (D) Social and economic conditions or circumstances;
  (E) The department's evaluation of personal information; and
  (F) Medical data, including diagnosis and past history of disease or disability; and

(2) The conditions for release of information by the department shall be in accordance with the provisions of chapter 17-1702.

(b) Recipients shall have freedom in the selection of any qualified medicaid provider from whom the recipient may obtain services, in accordance with the provisions of chapter 17-1736.

(c) Providers of long-term institutional services shall submit to the department a written incident report for each incident that result in harm to the medicaid recipient. These reportable incidents include, reaction to a drug or therapy, all bodily injuries that require medical intervention, and absence without leave for one or more nights. An incident report shall be in writing and shall be submitted to the department within seventy-two hours of a reportable incident. Written reports shall include the following:

(1) Name of the NF or ICF-MR;
(2) Name, age, and birthdate of the recipient;
(3) Resident's diagnosis;
(4) Resident's acuity level at time of incident;
(5) Date, time, and place of the incident;
(6) Description of how the incident occurred;
(7) Description of the kind and extent of medical intervention; and
(8) Date incident report was written, and signature and title of the reporting individual.

(d) Providers of long-term institutional services shall admit and provide NF or ICF-MR levels of care,

treatment, and services to medicaid recipients without discrimination, separation, or any other distinction on the basis of race, color, national origin, or mental or physical handicap in accordance with the provisions of chapter 17-1736.

(e) For NFs and ICF-MRs, medical records shall be retained three years from the date of a resident's discharge from the provider's care. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10; Pub. L. No. 100-203) (Imp: HRS §346-40; 42 C.F.R. §§431.51, 431.115, 431.301, 431.305; 29 U.S.C. §794; 42 U.S.C. §2000d; Pub. L. No. 100-203)

§17-1737-38 Termination of long-term institutional services. (a) Medicaid payments for long-term institutional services shall be terminated when a recipient is deemed to no longer require a specific level of care in accordance with the provisions of section 17-1737-31 and the recipient refuses to transfer to an available appropriate placement.

(b) The provider agreement shall be terminated when the provider fails to provide long-term institutional services in accordance with the terms stipulated in the provider agreement.

(c) The appeal and hearing provisions of chapter 17-1736 shall apply. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 C.F.R. §§431.152, 431.202)

§17-1737-39 Sharing of federal financial participation payment penalty assessment. (a) The department shall allocate to the provider any or all federal financial participation payment penalties which are assessed the department by the Health Care Financing Administration of the Department of Health and Human Services for provider's failure to meet the utilization control requirements in accordance with the provisions of sections 17-1737-34 and 17-1737-35.

(b) The amount shall be determined by a committee composed of representatives from the department and other interested private and public agencies.

(c) The appeal and hearing provisions of chapter 17-1736 shall apply. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 C.F.R. §§431.152, 431.202)

§17-1737-40 Remedies for nursing facilities that do not meet the requirements for participation. (a) The department shall impose one or more of the following remedies when a nursing facility does not meet one or more of the requirements of participation and its deficiencies constitute immediate jeopardy or widespread actual harm that does not constitute immediate jeopardy to the health and safety of its residents:

(1) Remove the jeopardy and appoint temporary management to oversee correction of the deficiencies and assure the health and safety of the facility's residents while corrections are being made to bring the facility into compliance with all of the requirements of participation, or to oversee orderly closure of a facility.

(A) Temporary management shall be state personnel, private individuals, or a team with education and requisite work experience in nursing home administration that qualifies the individual(s) to correct the deficiencies in the facility to be managed; and be licensed in accordance with state law. The following individuals are not eligible to serve as temporary managers:

(i) Any individual who has been found guilty of misconduct by any licensing board or professional society in any state;

(ii) Has or whose immediate family members have any financial interest in the facility managed; or

(iii) Currently serves or, within the past two years, has served as a member of the staff of the facility;

(B) Facility management must agree to relinquish control to the temporary manager and to pay his or her salary before the temporary manager can be installed in the facility. The facility cannot retain final authority to approve changes of personnel or expenditures of facility funds and be considered to have

relinquished control to the temporary manager;

(C) If the facility refuses to relinquish control to the temporary manager, the facility shall be terminated;

(D) A temporary manager has the authority to hire, terminate, or reassign staff, obligate facility funds, alter facility procedures, and otherwise manage a facility to correct deficiencies identified in the facility operation. The temporary manager must be given access to facility bank accounts that include receipts;

(E) A temporary manager may be imposed fifteen days after the facility receives notice, in non-immediate jeopardy situations; and two days after the facility receives notice, in immediate jeopardy situations; and

(F) Temporary management shall continue until a facility is terminated, achieves substantial compliance and is capable of remaining in substantial compliance, or decides to discontinue the remedy and reassumes management control before it has achieved substantial compliance, in which case the facility faces termination;

(2) Assess civil money penalty, with interest, and impose civil money penalty for the number of days that a facility is not in substantial compliance with one or more participation requirements, regardless of whether or not the deficiencies constitute immediate jeopardy and for the number of days of past noncompliance since the last standard survey, including the number of days of immediate jeopardy.

(A) Civil money penalties may be imposed as a remedy for past noncompliance that is corrected at the time of the current survey. Situations for consideration of a civil money penalty may include, but may not be limited to, facilities that cannot consistently sustain substantial compliance with the requirements as noted in the facility-specified reports,

substantiated complaints, or situations which indicate that the facility did not act to prevent a situation of noncompliance from occurring;

(B) The amount of the civil money penalty shall be on the lower range of $50 to $3,000 per day or on the upper range of $3,050 to $10,000 per day. A civil money penalty shall not be less than $50;

(C) Factors to be considered in determining the amount of the civil money penalty are:

(i) The facility's history of noncompliance, including repeated deficiencies;

(ii) The facility's financial condition;

(iii) Seriousness and scope of the deficiencies;

(iv) Likelihood that the civil money penalty will achieve correction and continued compliance;

(v) The facility's degree of culpability; and

(vi) Any other remedies being imposed in addition to the civil money penalty;

(D) All funds collected as a result of these civil money penalties shall be applied to the protection of the health and property of the residents of the facility;

(E) The funds shall be used for:

(i) Payment for the cost of relocating residents to other facilities;

(ii) State costs related to the maintenance or operation of a facility pending correction of deficiencies or closure;

(iii) Reimbursement of residents for personal funds or property lost as a result of actions by the facility or by individuals used by the facility to provide services to residents; and

(iv) Other costs related to the health and property of the residents, such as, the cost of having resident medical records sealed, secured,

and stored; the cost of picking up and transferring or delivering resident medications or drugs; the cost of using ambulance service; and etc.;

(F) The civil money penalty may start accruing as early as the date the facility was first out of compliance, as determined by HCFA or the State. A civil money penalty cannot be collected until a provider requests a hearing. When no hearing is requested, payment of a civil money penalty will be due fifteen days after the time period for requesting a hearing has expired and a hearing request was not received or after the final administrative decision which includes a hearing and review; and

(G) A notice of imposition of civil money penalty shall be sent to the facility and shall include the following information:

(i) Nature of the noncompliance (regulatory requirements not met);

(ii) Statutory basis for the penalty;

(iii) Amount of penalty per day of noncompliance;

(iv) Factors that were considered in determining the amount of the penalty;

(v) Date on which the penalty begins to accrue;

(vi) Statement that the penalty will stop accruing on the date on which that facility comes into substantial compliance or is terminated from participation in the program;

(vii) When the penalty shall be collected; and

(viii) Statement of the facility's right to a hearing and information regarding how to request a hearing, implications of waiving the right to a hearing, and information regarding how to waive the right to a hearing;

(3) Close the nursing facility or transfer the residents to other facilities or both, to minimize the period of time during which residents are receiving less than adequate care.
   (A) A finding of immediate jeopardy will not require the State to close a facility and transfer residents. It may result in the immediate termination of provider agreement and the subsequent transfer of residents;
   (B) During an emergency which relates to the facility's gross inability to provide care and related services because of fire, natural disaster, epidemic, or other conditions endangering the health and safety of the residents, the State may permanently or temporarily transfer residents to another facility until the original facility is again able to care for its residents; and
   (C) Transfer requirements shall apply to only Medicare and Medicaid residents and not to private pay residents;

(4) Terminate the nursing facility's Medicaid participation.
   (A) When there is immediate jeopardy to residents' health and safety, termination procedures shall be completed within twenty-three days from the last day of the survey which found the immediate jeopardy, if the jeopardy is not removed before then;
   (B) When there is no immediate jeopardy, HCFA or the State may terminate a facility if the facility does not come into substantial compliance within six months of the date of the survey that found it to be out of substantial compliance; and
   (C) Termination may be imposed by the State at any time when appropriate for any noncompliance. The facility's compliance history shall be taken into account when considering whether or not to terminate a facility's provider agreement;

(5) Impose denial of payment for new admissions when a facility has been found to have

provided substandard quality of care on the last three consecutive standard surveys, regardless of other remedies imposed.

(A) Deny payment for all new admissions within the third month from the last day of the third consecutive survey.

(B) Facility shall be given written notice at least two days before the effective date in immediate jeopardy cases and at least fifteen days before the effective date in all others;

(C) Optional denial of payment for all new admissions shall be imposed only when the facility makes little or no effort to come into substantial compliance, e.g., when it fails to adhere to its plan of correction;

(D) Mandatory denial of payment for all new admissions shall be imposed when the facility is not in substantial compliance by the third month after the last day of the survey identifying the deficiency or when a provider has been found to have furnished substandard care on the last three consecutive standard surveys;

(E) The denial of payment remedy may be imposed at other times singly or in conjunction with other remedies, when a facility is not in substantial compliance;

(F) The denial of payments shall continue until the State has verified that the facility has achieved substantial compliance. Payment resumes prospectively from the date the State has determined that substantial compliance is achieved.

(i) When payment is denied for repeated instances of substandard quality of care, the remedy shall not be lifted until the facility is in substantial compliance and the State or HCFA believes that the facility will remain in substantial compliance; and

(ii) If payment is denied for any other reason and, if a survey team finds written credible evidence that the

facility corrected deficiencies or was in substantial compliance before the date the survey agency received the credible evidence, the remedy shall be lifted as of that date;

(G) No payments shall be made for the period between the date the remedy was imposed and the date that substantial compliance was achieved; and

(H) Residents admitted before and discharged before the effective date of the denial of payment are considered new admissions, if readmitted, and are subject to the denial of payment; and

(6) State monitoring shall be imposed when a facility has been found on three consecutive standard surveys to have provided substandard quality of care.

(A) State monitoring shall oversee the correction of cited deficiencies in the facility as a safeguard against further harm to residents when harm or a situation with a potential for harm has occurred. State monitoring shall include:

(i) Providing special consultative services to a facility for obtaining the type of training and basic knowledge needed to achieve and remain in compliance with federal regulations or to attend an in-service training program likely to correct the deficiencies; and

(ii) Assisting in the development of an acceptable plan of correction;

(B) Situations when state monitoring may be appropriate include, but are not limited to, the following:

(i) Poor facility history, i.e., a pattern of poor quality of care, many complaints, etc.;

(ii) State agency concern that the situation in the facility has the potential to worsen;

(iii) Immediate jeopardy exists and no temporary manager can be appointed or the facility refuses to relinquish control to a

temporary manager. A monitor shall be imposed to oversee termination procedures and transfer of residents; or

(iv) The facility seems unable or unwilling to take corrective action for cited substandard quality of care;

(C) Monitoring may occur anytime in a facility, i.e., twenty-four hours a day, seven days a week, if necessary. In all instances, monitors shall have complete access to all areas of the facility as necessary for performance of the monitoring task; and

(D) State monitoring shall be discontinued when:

(i) The facility's provider agreement is terminated; or

(ii) The facility is terminated; or the facility has demonstrated to the satisfaction of HCFA or the State Agency, that the facility is in substantial compliance with the requirements and (if imposed for repeated substandard quality of care) that the facility will remain in substantial compliance.

(b) The appeal and hearing provisions of chapter 17-1736 shall be available to providers subject to state imposed remedies. [Eff 08/01/94; am 01/29/96; am 11/25/96; am 09/14/98] (Auth: HRS §346-14; 42 C.F.R. §§442.118, 442.119; Pub. L. No. 100-203) (Imp: Pub. L. No. 100-203; 42 C.F.R. §§431.152, 431.202, 442.118, 442.119)

§§17-1737-41 to 17-1737-42 (Reserved).

SUBCHAPTER 5

PREVENTIVE AND REHABILITATIVE SERVICES

§17-1737-43 Preventive services. (a) Preventive services means services provided by a physician or other licensed practitioner of the

healing arts within the scope of a practice under state law to:

(1) Prevent disease, disability, and other health problems or their progress;

(2) Prolong life; and

(3) Promote physical and mental health and efficiency.

(b) Medical payments to providers may be made on behalf of recipients for the following services:

(1) Physical examinations for the following purposes:

(A) School health clearances;

(B) Pre-admissions and periodic physicals required by Public Health Regulation 12-B for care homes;

(C) Pre-placement physicals for adults entering family boarding homes;

(D) Premarital examinations;

(E) Examinations to determine the extent of mental or physical disability or incapacity;

(F) Pre-placement and annual examinations for children in foster care;

(G) Pre-adoption pediatric examinations;

(H) Employability determinations and WIN pre-referral examinations;

(I) Examinations when indicated is suspected child abuse cases, if eligible for medical assistance;

(J) Pre-placement examinations for day care; and

(K) Other health examinations limited to not more than once in a two year period.

(2) Routine laboratory examinations necessary to complete the physicals, as well as diagnostic screening; and

(3) Immunizations and vaccinations, with the exception of pediatric vaccines covered under the Vaccines for Children (VFC) program and immunizations for travel to foreign countries. [Eff 08/01/94; am 01/29/96] (Auth: HRS §346-14) (Imp: 42 C.F.R. §440.130)

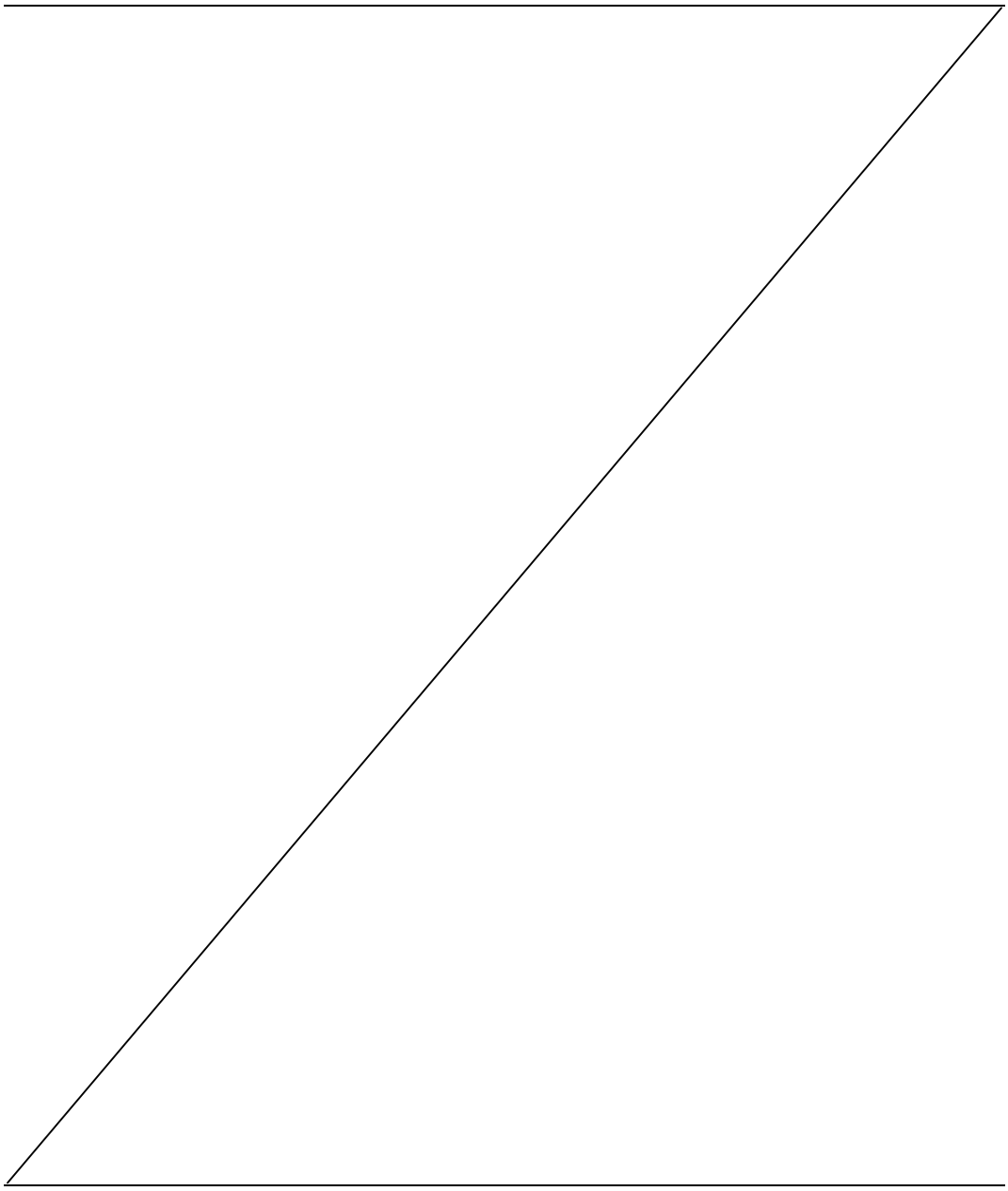
§17-1737-44 Rehabilitative services. (a) Rehabilitative services means those medical and remedial items or services which are prescribed by a

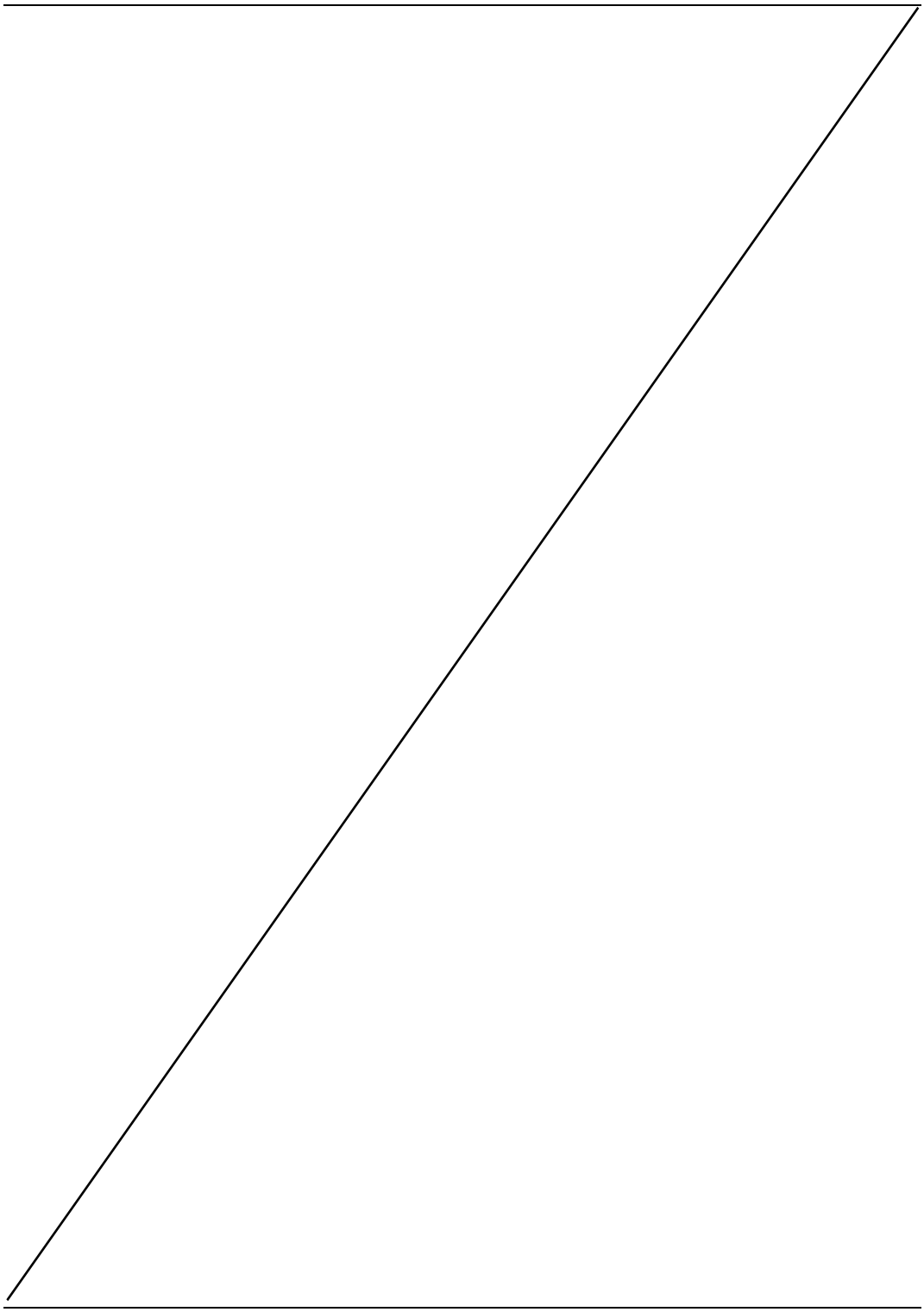
licensed physician for the purpose of maximum reduction of a patient's physical or mental disability and restoration of the patient to the patient's best possible functional level.

(b) Rehabilitative services shall be directed to restoring a disabled person toward the following goals:

(1) Self-care and possible independent living; or

(2) Substantial gainful employment.





(c) Children through six years of age shall meet the following conditions to show rehabilitative services are reasonable and necessary:

(1) The services shall be considered under accepted standards of medical practice to be a specific and effective treatment for the patient's condition. Experimental therapies are excluded from coverage;

(2) An expectation that the condition will improve significantly in a reasonable and generally predictable period of time based on the assessment made by the physician of the patient's rehabilitative potential after any needed consultation with the qualified therapist or, services are necessary to establish a safe and effective maintenance program required in connection with a specific developmental or disease state;

(3) The services required can be safely and effectively performed only by a qualified therapist/pathologist or under the immediate supervision of a therapist because the services are complex or because of the child's medical or physical condition;

(4) The amount, frequency, and duration of the services shall be reasonable and subject to authorization by the department. Additionally, the provisions and limitations pertaining to the specific rehabilitation service such as physical therapy, speech therapy, etc. addressed in this chapter and chapter 17-1739 shall apply;

(5) Referrals for therapeutic services shall be made by a physician. The physician is expected to employ clinical judgment, the history and physical, testing, etc. in determining the medical necessity of rehabilitative services; and

(6) Evaluation of the patient's developmental or therapeutic status shall be measured and expressed in objective, unambiguous concise language. The results of tests as well as goals, and therapeutic results shall be recorded on appropriate forms and may be reviewed by the department.

(d) Medical vendor payments may be made for the following types of services whether provided on an inpatient or an outpatient basis:

(1) Corrective surgery;
(2) Physical therapy;
(3) Speech therapy;
(4) Occupational therapy;
(5) Drugs, prosthetics, and durable medical equipment and supplies; and
(6) Other related restorative services.
[Eff 08/01/94; am 02/10/97] (Auth: HRS §346-14) (Imp: 42 C.F.R. §440.130)

§17-1737-45 Home health services. (a) Home health services means services provided to a recipient by a home health agency or under a home or community-based waiver:
(1) At the recipient's place of residence or at a location other than a hospital, skilled nursing facility, intermediate care facility - mental retardation, or intermediate care facility;
(2) On a physician's orders as part of a written plan of care that the physician reviews every sixty days; and
(3) Medical authorization as specified in section 17-1739-4 is needed for all home health services, medical supplies, equipment and appliances unless otherwise specified under this section.
(b) Home health services shall include:
(1) Nursing service, as defined in chapter 457, HRS provided on a part-time or intermittent basis;
(2) Home health aide services;
(3) Medical supplies, equipment, and appliances suitable for use in the home, subject to prior authorization as specified in section 17-1739-4;
(4) Physical therapy, occupational therapy, speech pathology and audiology services subject to prior authorization as specified in section 17-1739-4; and
(5) Medical social services and other services not specifically listed in this section are not covered.
(c) Reimbursement for home health services shall be limited to the following:
(1) Home health services shall be reimbursable on the basis of "per visit". A visit shall

encompass approximately one or two hours of service;

(2) One visit per day only;

(3) Daily home visits without medical authorization are permitted for home health aide and nursing services in the first two weeks of care if part of the written plan of care;

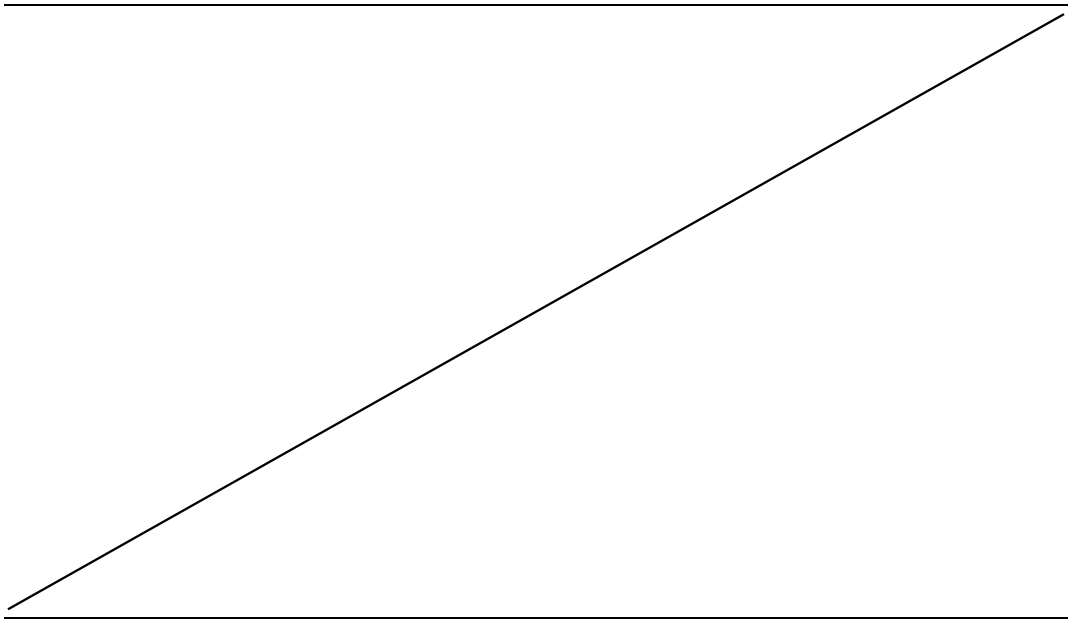
(4) Initial physical therapy and occupational therapy evaluations only without medical authorization are permitted if part of a written plan of care;

(5) No more than three visits a week for each service shall be reimbursed for the third week to the seventh week of patient care;

(6) No more than one visit a week for each service shall be reimbursed from the eighth week to the fifteenth week of patient care;

(7) No more than one visit every other month for each service shall be reimbursed from the sixteenth week of patient care; and

(8) Services exceeding the parameters of this section shall be prior authorized by the department's medical consultant or its authorized representative. [Eff 08/01/94; am 02/10/97] (Auth: HRS §346-14) (Imp: 42 C.F.R. §§440.70, 441.15)



§17-1737-46 Family planning services. (a) All fee for service medicaid recipients, male or female, including minors, who are sexually active or of child-bearing age, shall be eligible for family planning services and supplies.

(b) The department shall furnish assistance to any eligible person by:

(1) Locating and referring to a recognized provider those persons encountering difficulties in obtaining family planning services; and

(2) Prompt attention so that the eligible person shall be assured of receiving family planning service within thirty days from the time of the request.

(c) The use of family planning services or practices shall be entirely on a voluntary basis. At no time shall any member of the department's staff place a recipient under any obligation, duress, compulsion, or use any other form of coercion on the recipient to accept or reject family planning services.

(d) Family planning information shall be disseminated by:

(1) Promptly informing new recipients of medical assistance of the availability of family planning services under the department's program, Title IV-A of the Social Security Act, and medicaid; and

(2) The branch worker hand issuing or mailing the department's information brochure entitled "Family Planning Services" to newly approved medical assistance recipients.

(e) Family planning services shall include:

(1) Consultation, counseling, examination including breast and pelvic examination, and treatment by or under the supervision of a physician or prescribed by a physician;

(2) Laboratory examinations and tests;

(3) Medically approved methods, procedures, pharmaceutical supplies and devices to prevent conception;

(4) Natural family planning methods;

(5) Diagnosis for infertility; and

(6) Voluntary sterilization procedures.

[Eff 08/01/94; am 06/19/00] (Auth: HRS §346-14) (Imp: 42 C.F.R. §§441.20, 440.250, 440.40)

§17-1737-47 Hysterectomy. (a) Hysterectomy means a medical procedure or operation for the purpose of removing the uterus.

(b) Hysterectomies shall be covered under the medicaid program when medically necessary except when performed:

(1) Solely for the purpose of rendering an individual permanently incapable of reproducing; or

(2) Primarily for the purpose of rendering the individual permanently incapable of reproducing when there is more than one reason for the hysterectomy.

(c) Reimbursement for hysterectomies shall be made only if the following conditions have been met, regardless of the age of the patient or the medical condition for which the hysterectomy was performed:

(1) The physician authorized to perform the hysterectomy informs the individual or her representative, if any, orally and in writing, prior to the procedure that the hysterectomy will render the individual permanently incapable of reproducing; and

(2) The individual or her representative, if any, signs a written acknowledgement of receipt of that information; or

(3) If the individual is already sterile prior to a hysterectomy, the physician who performed the hysterectomy shall:

(A) Certify in writing that the person was sterile; and

(B) State the cause of the sterility; or

(4) If the individual required a hysterectomy because of a life threatening emergency, the physician shall:

(A) Certify that prior acknowledgement was not possible or practical; and

(B) Provide a description of the nature of the emergency.

For the purpose of this subsection, "sterility" shall be due to an established condition such as menopause, successful prior sterilization procedure or demonstrated bilateral tubal blockage due to disease. Lack of conception without demonstrated tubal blockage or endocrine dysfunction interfering with ovulation shall not be acceptable in meeting the definition of sterility. "Life threatening emergency" means actual emergencies such as a ruptured uterus or uteroplacental

apoplexy or severe abdominal trauma. A hysterectomy which becomes medically advised during an operative procedure shall not be considered a life threatening emergency. The possibility of an associated hysterectomy shall be considered in all pelvic or lower abdominal operative procedures and the proper tentative warning provided.

(d) The department shall obtain documentation, showing the requirements of this section were met, before making payments. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: 42 C.F.R. §§441.255, 441.256)

§17-1737-48 Sterilization. (a) Sterilization means any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing. Sterilization shall be neither a necessary part of the treatment of an existing accompaniment of an operation. Sterilization under this program shall not be authorized for any individual who is:

(1) Mentally incompetent;
(2) Incompetent under applicable state law to give informed and binding consent because of mental incapacity;
(3) Under twenty-one years; or
(4) Institutionalized.

(b) Informed consent shall be obtained prior to any sterilization procedure. For the purpose of this program, the informed consent shall be valid only if prior to obtaining the consent, the individual requesting the service was furnished with the following information:

(1) A thorough explanation of the procedure to be performed;
(2) A full description of the attendant discomforts and risks;
(3) A description of the benefits to be expected;
(4) Counseling concerning appropriate alternative methods, and the effect and impact of the proposed sterilization, including the fact that the procedure shall be considered irreversible;
(5) An offer to answer any inquiries concerning the sterilization procedures;
(6) Advice that the individual is free to withhold or withdraw the consent to the procedure without affecting the right to

future medicaid benefits and without prejudice to future care; and

(7) Advice that the sterilization will not be performed for at least thirty days except under conditions listed in subsection (e).

(c) The provider shall use the appropriate departmental form to obtain written consent from a medicaid recipient who is requesting the service. No substitution of form shall be accepted.

(d) Sterilization shall not be performed sooner than thirty days but not more than one hundred eighty days following the giving of informed consent in writing, except as explained in subsection (e).

(e) Exceptions to subsections (b)(7) and (d) may be made if more than seventy-two hours have passed since informed consent was given and where there is:

(1) Premature delivery, when informed consent was given at least thirty days before expected date of delivery; or

(2) Emergency abdominal surgery.

(f) Consent for sterilization may not be obtained if the person requesting sterilization is:

(1) In labor or childbirth;

(2) Seeking to obtain or is obtaining an abortion; or

(3) Under the influence of alcohol or other substances that affect the individual's state of awareness.

(g) An operation for an ectopic pregnancy which results in sterilization due to removal of a woman's single remaining fallopian tube shall not be considered either a primary sterilization or an abortion and shall be a medically indicated procedure covered under the program.

(h) A hysterectomy shall not be considered a sterilization procedure. The provisions of section 17-1737-47 shall apply. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: 42 C.F.R. §§441.250 - 441.258)

§17-1737-49 Respiratory care services. (a) Respiratory care services are services provided on a part time basis in the home of the individual by a respiratory therapist or other health care professional trained in respiratory therapy as defined in section 17-1737-2.

(b) Respiratory care services may be provided for

medicaid eligible individuals who meet the following criteria:

(1) Medically dependent on a ventilator support for at least thirty consecutive days as an inpatient in an acute or long term care facility;

(2) Dependent on ventilator support for at least six hours per day;

(3) If respiratory care services were not available, would require inpatient care in a hospital, or long-term care institution;

(4) Eligible or would be eligible for medicaid payments if institutional care were required;

(5) Has adequate support services to be cared for at home; and

(6) Wishes to be cared for at home.

(c) Authorization by the department on form DHS 1144 shall be required for the provision of respiratory care services.

(d) Medicaid payments for respiratory care services shall be made only to providers meeting the requirements of chapter 17-1736. [Eff 08/01/94] (Auth: HRS §346-14, 42 C.F.R. §431.10) (Imp: Pub. L. No. 99-509, Section 9408)

§17-1737-50 Home pharmacy services. (a) Home pharmacy services are services related to the dispensing and clinical monitoring of enteral and parenteral nutrition and therapeutic agents given intravenously or by injection to recipients in their homes.

(b) Home pharmacy services shall be ordered by a physician and shall include clinical monitoring by pharmacists and other skilled medical professionals, such as registered nurses.

(c) Home pharmacy services may be provided to Medicaid eligible individuals who:

(1) Require the use of therapeutic intravenous or injectable agents including analgesics, antibiotics, and fluids to treat their medical condition;

(2) Do not require acute hospital or nursing facility care, have adequate support in the home, and can safely receive these services in the home setting; and

(3) Wish to receive this care in the home.

(d) Authorization by the department for home pharmacy services on form DHS 1144 shall be required for the provision of home pharmacy services by freestanding pharmacies and by acute care hospital which provide home pharmacy services.

(e) Medicaid payments shall only be made when freestanding home pharmacy services are furnished by providers accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) as a freestanding home pharmacy or an acute hospital. Non-accredited providers who are currently furnishing freestanding home pharmacy services to Medicaid recipients shall obtain JCAHO accreditation by January 1, 1997. [Eff 11/25/96] (Auth: HRS §§346-14, 346-59) (Imp: HRS §§346-14, 346-59; 42 C.F.R. §431.10)

§17-1737-51 Sleep services. (a) Sleep services are services provided for the diagnosis and treatment of sleep disorders and shall:

(1) Be performed by sleep laboratories or sleep disorder centers; and

(2) Be provided to Medicaid eligible individuals only when ordered by a physician and authorized by the department on form DHS 1144.

(b) Medicaid payments shall only be made for sleep services furnished by sleep laboratories or sleep centers who are accredited by the American Sleep Disorders Association by January 1, 1997. [Eff 11/25/96] (Auth: HRS §§346-14, 346-59) (Imp: HRS §§346-14, 346-59; 42 C.F.R. §431.10)

§17-1737-52 (Reserved).

SUBCHAPTER 6

EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT)

§17-1737-53 Early and periodic screening, diagnosis, and treatment (EPSDT). (a) EPSDT means early screening and diagnostic services to identify physical or mental defects in recipients; and, to

provide health care, treatment, and other measures to correct or ameliorate any defects and chronic condition discovered.

(b) EPSDT includes services to:

(1) Seek out recipients and their families and inform them of the benefits of prevention and the health services available;

(2) Help the recipient or family use health resources, including their own talents, effectively and efficiently; and

(3) Assure the problems identified are diagnosed and treated early, before they become more complex and their treatment more costly.

[Eff 08/01/94] (Auth: HRS §346-14) (Imp: 42 C.F.R. §441.50)

§17-1737-54 Recipient eligibility requirements. Early and Periodic Screening, Diagnosis, and Treatment services shall be provided to eligible Medicaid recipients under age twenty-one. [Eff 08/01/94; am 06/19/00] (Auth: HRS §346-14) (Imp: 42 C.F.R. §441.56)

§17-1737-55 Informing. (a) The department shall seek out individuals and their families and inform them of the availability of EPSDT services by a combination of written and oral methods to effectively explain the benefits of prevention and the health services available:

(1) Within sixty days of the recipient's initial eligibility determination; and

(2) Annually thereafter in case of recipient or family who have not utilized EPSDT services.

(b) Written and oral methods used to inform recipients or their families shall be:

(1) Clear and nontechnical written materials; and

(2) Appropriate informing procedures for recipients or their families who are deaf, blind, or who cannot read or understand the English language.

(c) Information provided to recipients or their families shall include:

(1) Benefits of preventive health care;

(2) Services covered under the EPSDT program;

(3) Where and how to obtain EPSDT services;

(4) Availability of EPSDT services at no cost;

(5) Upon request by recipient or family, assistance with scheduling appointments for EPSDT services; and

(6) Upon request by recipient or family, assistance with transportation in accordance with subsection 17-1737-82(h) to receive EPSDT services.

(d) Newly eligible pregnant women shall be informed about the availability of EPSDT services. A positive response to an offer of EPSDT services during pregnancy constitutes a request for EPSDT services for the child at birth. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: 42 C.F.R. §§441.56, 441.62; 42 U.S.C. §1396d)

§17-1737-56 Periodicity schedule. (a) The scheduled frequency of medical screening services shall be based on age:

(1) Infancy: by one month, at two, four, six, nine, and twelve months;

(2) Early childhood: at fifteen, eighteen, and twenty-four months and at three and four years;

(3) Late childhood: at five, six, eight, ten, and twelve years; and

(4) Adolescence: at fourteen, sixteen, eighteen, and twenty years.

(b) The scheduled frequency of the dental screening services shall be a maximum of one screening/examination visit once every six months for children six months to twenty years of age.

(c) Interperiodic screens which are medically necessary to determine the existence of suspected physical or mental illness or conditions, shall be provided without regard to the schedules in subsections (a) and (b). [Eff 08/01/94] (Auth: HRS §346-14) (Imp: 42 C.F.R. §§441.58, 441.59; 42 U.S.C. §1396d)

§17-1737-57 Screening. (a) Upon request from the recipient or family, the department shall assess

the recipient's health status and needs through initial and periodic health examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth. Screening shall include, but not be limited to:

(1) Comprehensive health and developmental history, including assessment of both physical and mental health development;
(2) Comprehensive unclothed physical examination;
(3) Appropriate immunizations according to age and health history;
(4) Appropriate vision testing;
(5) Appropriate hearing testing;
(6) Appropriate laboratory tests, including lead blood level assessment appropriate for age and risk factors;
(7) Routine dental examination furnished by direct referral to a dentist which includes bitewing x-ray, scaling and polishing, and topical application of fluoride as deemed necessary in accordance with section 17-1737-75; and
(8) Health education including anticipatory guidance.

(b) The dental screening, to be completed by the dentist, includes but is not limited to an oral examination, diagnosis and assessment of any oral disease or injuries, oral hygiene instructions, dietary counseling relating to dental health, and injury prevention counseling. Appropriate reading materials and a toothbrush, at no charge to the patient, are included in the screening fee. Preventive education and assessment shall be included as follows, by age:

(1) Age twelve to twenty-four months - complete the clinical oral exam and appropriate diagnostic tests to assess oral growth and development and/or pathology; provide oral hygiene counseling for parents, guardians and caregivers; remove supra-and subgingival stains or deposits as indicated; assess the child's systemic fluoride status and provide fluoride supplementation if indicated, following drinking water analysis; assess appropriateness of feeding practices; provide dietary counseling relating to oral health; provide injury prevention counseling for orofacial trauma (play objects, pacifiers, car seats, etc.); provide counseling for oral

habits (digit, pacifiers, etc.); provide diagnosis and required treatment for any oral disease or injuries; provide anticipatory guidance for parent/guardian; assess topical fluoride status and give parental counseling; provide injury prevention counseling for orofacial trauma (learning to walk, run, etc.);

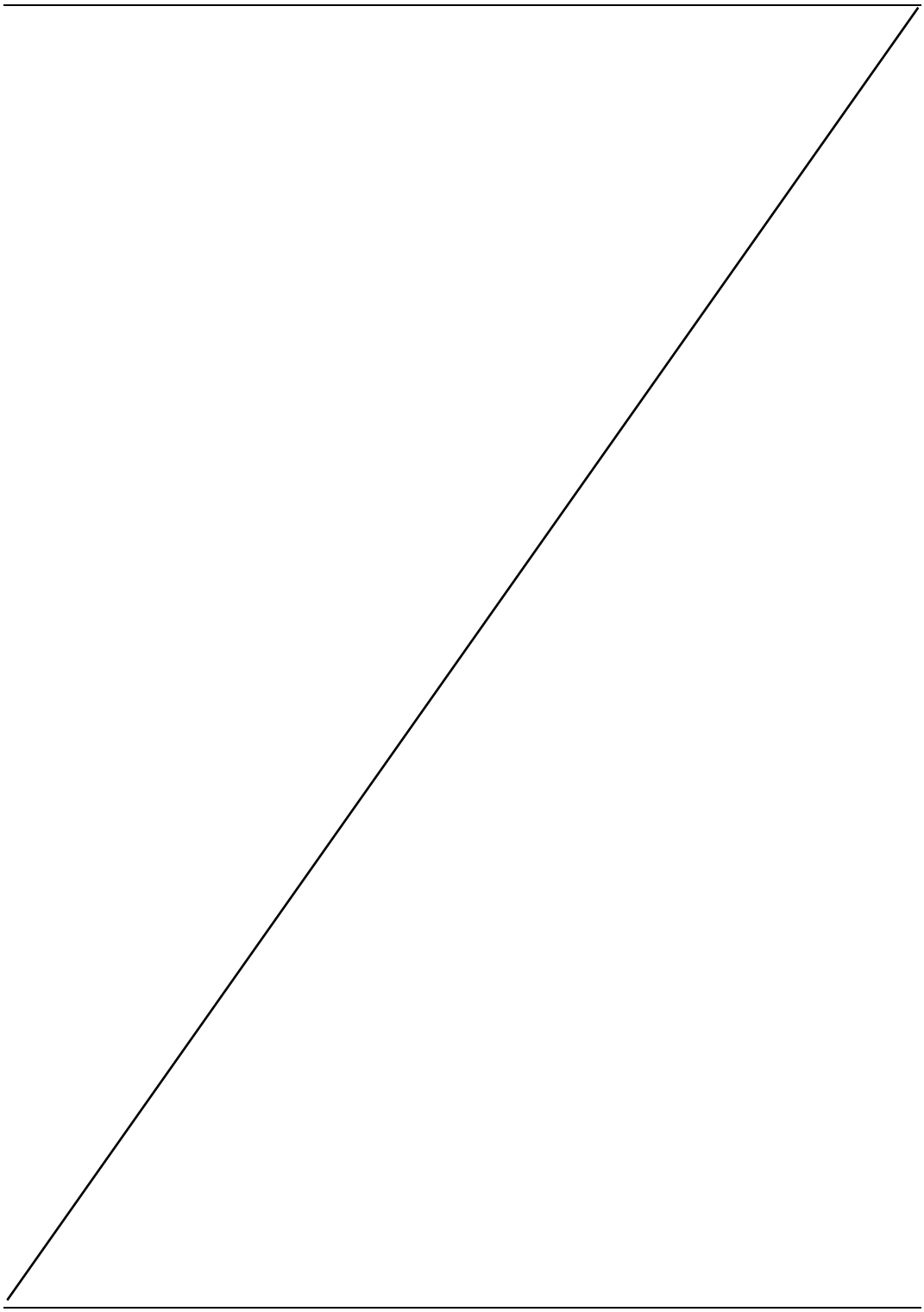
(2) Age two to six years - repeat twelve to twenty-four month procedures every six months or as indicated by individual patient's needs/susceptibility to disease; provide age-appropriate oral hygiene instructions; complete a radiographic assessment of pathology and/or abnormal growth and development, as indicated for individual patient's needs; scale and clean the teeth every six months or as indicated by the individual patient's needs; provide topical fluoride treatments every six months or as indicated by the individual patient's needs; provide pit and fissure sealants for permanent teeth as indicated by the individual patient's needs; provide counseling and services (athletic mouth guards) as needed for orofacial trauma prevention; provide assessment/treatment or referral of developing malocclusion as indicated by individual patient's needs; treat any oral disease/habits/injuries as indicated;

(3) Age six to twelve years - repeat two to six year procedures every six months or as indicated by individual patient's needs/susceptibility to disease; provide injury prevention counseling/services for orofacial trauma (sports activities); provide substance abuse counseling (smoking, smoke less tobacco, etc.); and

(4) Age twelve to twenty years - repeat six to twelve year procedure every six months or as indicated by individual patient's needs/susceptibility to disease.

[Eff 08/01/94; am 11/25/96] (Auth: HRS §346-14) (Imp: 42 C.F.R. §441.56; 42 U.S.C. §1396d)

§17-1737-58 Diagnosis and treatment. (a)



Diagnostic and treatment services shall be provided for problems identified during screening regardless of whether the service is included in the department's state plan. Provision of services that are not included in the state plan shall be based on medical necessity and require prior authorization, and shall be limited to services permitted under medicaid.

(b) Assistance in referral shall be provided for treatment services not covered by the medical assistance program (medicaid), but determined to be needed as a result of problems identified during screening and diagnosis. Assistance in referral only shall include giving the recipient or family the names, addresses, and telephone numbers of providers who are able to furnish the needed treatment at little or no cost to the recipient or family.

(c) Dental care, at as early an age as necessary for relief of pain and infections, restoration of teeth and maintenance of dental health in accordance with section 17-1737-75. Dental diagnosis and treatment shall be started within sixty days of the screening date and the treatment plan shall be completed within one hundred-twenty days from the date a procedure was initiated, except under noted extenuating circumstances.

(d) Diagnostic and treatment services shall be started within six months from the request for screening services by the recipient or family. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: 42 C.F.R. §§441.56, 441.61; 42 U.S.C. §1396d)

§17-1737-59 EPSDT providers. EPSDT providers shall deliver either directly or indirectly through referral EPSDT services as set out in sections 17-1737-53 to 17-1737-58. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: 42 C.F.R. §§441.56, 441.58, 441.61)

§17-1737-60 Continuing care provider. (a) Continuing care means EPSDT services provided by a medical professional familiar with the recipient's episodes of acute illness; and who has an ongoing relationship with the recipient or family as their regular source of health care.

(b) Continuing care provider shall deliver EPSDT services as set out in sections 17-1737-54 to 17-1737-59 with the exception of dental services, and provide physician services as needed by the recipient

for acute, episodic, or chronic illnesses or conditions.

(1) Recipient or family shall agree to use the continuing care provider of their choice as their regular source of continuing care services.

(2) Provider and recipient or family shall sign statements that reflect their respective obligations under the continuing care arrangement. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: 42 C.F.R. §441.60)

§17-1737-61 Provider requirements for participation in the medical assistance program. (a) Participation in the program as an EPSDT or a continuing care provider is open to public and volunteer clinics and health agencies, health maintenance organizations, prepaid health plans, group practices, and solo practitioners. EPSDT provider and continuing care provider shall meet all the requirements as set out in chapter 17-1736.

(b) EPSDT provider and continuing care provider approved by the department for program participation shall enter into a contractual agreement with the department. Contractual agreement shall include but not be limited to:

(1) Provider responsibility to maintain recipient's consolidated health history, including information received from other providers; and

(2) Department's responsibility to reimburse for:

(A) Medical screening services based on a negotiated per patient rate; and

(B) Routine dental examinations in accordance with the fee schedule established for the fee for services component of the medical assistance program (medicaid). [Eff 08/01/94] (Auth: HRS §346-14) (Imp: 42 C.F.R. §§431.10, 441.60)

§17-1737-62 Appeal and hearing. An appeal and hearing process in accordance with chapter 17-1736 shall be available to all EPSDT providers and continuing care providers. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: 42 C.F.R. §431.10)

§§17-1737-63 to 17-1737-70 (Reserved).

SUBCHAPTER 7

ANCILLARY MEDICAL SERVICES

§17-1737-71 Drugs. (a) Medical assistance payments shall be made for drugs when dispensed to eligible recipients within the following guidelines:

(1) When prescribed by a practitioner licensed by the state;

(2) The drug has been approved by the U.S. Food and Drug Administration for the purpose for which it is prescribed;

(3) The drug can be expected to be of therapeutic value for the disease or condition under treatment; and

(4) The drug complies with the medicaid drug formulary or prior authorization has been obtained from the department's medical consultant or pharmacy consultant for its use.

(b) A drug formulary shall be maintained as follows:

(1) An advisory formulary committee shall be appointed by the director of the department, and shall consist of:

(A) A committee consisting of physicians, pharmacists, and other appropriate individuals; or

(B) At the option of the State, the State's drug use review (DUR) board;

(2) The formulary committee's secretary or drug use review coordinator shall be representatives of the department and selected by the director;

(3) The duties of the advisory drug formulary committee shall be to:

(A) Meet when called by the chairperson;

(B) Develop and maintain a current and effective drug formulary;

(C) Advise the department of necessary changes; and

(D) Require prior authorization for the use of specific drug products and establish

the criteria under which authorization for use is appropriate;

(4) Actions of the advisory drug formulary committee shall be:

(A) Subject to the approval of the med-QUEST administrator;

(B) Circulated to appropriate providers; and

(C) Effective upon receipt by providers unless otherwise stated; and

(5) The term of each formulary committee member shall be two years and overlapped in such a way that expiration of term does not cause a total membership change, or subject to the bylaws of the drug use review board.

(c) The drug formulary shall contain:

(1) Drugs approved by the U.S. Food and Drug Administration for human use and whose manufacturers' have entered into rebate agreement with the Health Care Financing Administration;

(2) Drug products which are safe, economical, and effective;

(3) No experimental or drug products on clinical study; and

(4) Rules pertinent to the dispensing of medications. [Eff 08/01/94; am 11/13/95; am 03/30/96] (Auth: HRS §346-14) (Imp: 42 C.F.R. §440.120, P. L. No. 103-66)

§17-1737-72 Durable medical equipment. (a) Durable medical equipment means equipment prescribed by a licensed physician to meet the medical equipment needs of a patient. Durable medical equipment includes, but is not limited to, wheelchairs, walkers, crutches, canes, hospital beds, side rails, respirators, and oxygen equipment.

(b) Durable medical equipment may be provided if it is:

(1) A medically necessary modality in the treatment of a medical condition;

(2) Necessary to assist the recipient in meeting or improving activities of daily living;

(3) Recommended by the attending physician for medical care of a patient; or

(4) Suitable for use in the recipient's place of residence.

(c) Ramps for wheelchairs may be provided with

prior authorization when necessary to accomplish activities of daily living.

(d) Medical equipment or appliances, when not available in the department's inventory, may be provided through rental or purchase, depending on the physician's opinion about the length of time the recipient will require use of the equipment.

(e) Rental payment for durable medical equipment or appliances shall cease and the item will have been purchased by the state when rental payments become equal to the purchase price.

(f) When an item is purchased during a rental period but before the rental paid equals the purchase price, all rental payments will be credited toward the purchase price of that item.

(g) Durable medical equipment shall not be provided to recipients who are patients in acute hospitals or long-term care facilities.

(h) Prior authorization shall be required for the purchase, cumulative rental, or repair of durable medical equipment when the cost to the program exceeds $50.

(i) The following items shall not be covered by the medical assistance program:

(1) Books;
(2) Air conditioners;
(3) Television sets;
(4) Massagers;
(5) Household items and furnishings including standard, orthopedic, or water beds;
(6) Fans;
(7) Air purifiers;
(8) Computers;
(9) Telephones; and
(10) Other items not generally used primarily for health care.

(j) The medical consultant may change a request for durable medical equipment to a less expensive make or model when the basic functions of the desired equipment are met.

(k) Durable medical equipment purchased by the medicaid program may be re-claimed by the department when no longer useful to the client. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: 42 C.F.R. §440.120)

§17-1737-73 Medical supplies. (a) Medical supplies means medical items prescribed by a licensed physician that are medically necessary for the treatment, care, or observation of a medical condition.

(b) Medical supplies include, but are not limited to, insulin syringes and needles, ostomy appliances and supplies, urine test materials, contraceptive devices, incontinence pads or devices, catheters, urine bags and tubing, ice bags, and hot water bottles or heating pads.

(c) Prior authorization shall be required when the original or cumulative cost of the items prescribed exceeds $50, except for intra-uterine devices for family planning purposes for which the cost may exceed $50.

(d) The following items shall not be covered by the program:

(1) Tooth brushes of any type, including standard or mechanical, except when distributed through the EPSDT program and included as part of the oral screening visit, water cleansing devices, toothpaste, denture cleaners, and mouth washes;
(2) Baby oil and powder;
(3) Sanitary napkins;
(4) Health food and food supplements;
(5) Non-medicated shampoos;
(6) Soaps including medicated soaps;
(7) Lip balm;
(8) Band aids; and
(9) Prepared food formula except when necessary for nutrition due to inborn metabolic abnormalities, abnormalities of digestion or absorption, or when persons are being fed by nasogastric, gastrostomy or jejunostomy tube. Milk substitutes and related compounds may be made available under this exception with prior authorization; and
(10) Other supplies not primarily medical in nature. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: 42 C.F.R. §§440.20, 440.90)

§17-1737-74 Prosthetic and orthotic appliances. (a) Prosthetic and orthotic appliances means those appliances prescribed by a physician, dentist, or podiatrist for the restoration of function or replacement of functional body parts.

(b) Prior authorization shall be required when the original or cumulative cost for purchase, repair, or manufacture of the appliances exceeds $50, except for dental prosthetic appliances which are covered under section 17-1737-75.

(c) The following items may be covered by the medical assistance program:

(1) Stock prosthetic eyes to prevent the problems associated with an empty eye socket;

(2) Stock conventional and stock orthopedic shoes when prescribed by a physician and provided by a prosthetist or an orthotist and when at least one of the shoes will be attached to a brace or prosthesis;

(3) Stock orthopedic shoes and high-topped shoes for children under the age of six years;

(4) Modification of stock conventional or orthopedic shoes when medically necessary;

(5) Custom-made orthopedic shoes when there is a clearly established medical need that cannot be satisfied by the modification of stock conventional or orthopedic shoes; and

(6) Implanted breast prosthesis provided the surgical procedure of implantation is approved by the department.

(d) Testicular prosthesis shall not be included in the medical assistance program.

[Eff 08/01/94] (Auth: HRS §346-14) (Imp: 42 C.F.R. §§440.120)

§17-1737-75 Dental services. (a) Dental services means diagnostic, preventive, and corrective procedures administered because of a diseased condition, injury, or impairment, by or under the supervision of a dentist licensed under state law for the treatment of teeth and the associated structures of the oral cavity.

(b) Dental services for individuals under the age of twenty-one are limited to the following services:

(1) Emergency treatment which includes services to relieve dental pain, eliminate infection, and treatment of acute injuries to the teeth and supporting structures of the oro-facial complex;

(2) X-ray with the limitations of one set of two bitewing rediographs during a twelve-month period and one set of full month rediographs

during a five-year period, including bitewings;

(3) Preventive dental services:
  (A) Topical application of fluoride limited to children up to age eighteen, once every six months;
  (B) Sealants for occlusal surface of permanent molar teeth only for children ages six through fifteen; and
  (C) Dental examination and prophylaxis treatment, which shall be limited to not more than once every six months, and which shall not cover routine examination of institutional patients;

(4) Periodontic treatment limited to cases of medical necessity, includes in the procedure, post operative care for six months following treatment and recall treatment limited to three times a year. Prior authorization and a medical report is required: Osseous and mucogingival surgeries, grafts, and implants are considered elective and are not covered;

(5) Intravenous or inhalation anesthesia which shall be allowed only once per treatment plan, for a specific procedure limited to cases of medical necessity. Prior authorization and a medical report is required;

(6) Root canal therapy with the following requirements:
  (A) Root canal therapy shall be covered for a maximum of once per tooth, except in cases of poor prognosis, as in the case of advanced decay or bone loss or prior root canal failure. Completed root canal x-rays shall be submitted with the claim for payment;
  (B) Root canal therapy shall not be covered for the purpose of overdenture fabrication except under special medical circumstances which requires prior authorization and a medical report;

(7) Extraction, whether done in the dentist's office or in a hospital under general anesthesia;

(8) Restorative dentistry with the following limitations:

(A) Restorative dentistry shall be limited to the use of amalgam, silicate, plastic, acrylic, or composite fillings;
(B) Non-duplicated restorative procedures are allowed only once per tooth every two years as needed in the treatment of fractured or carious teeth;
(C) Acrylic jackets and acrylic veneer crowns, if authorized, shall be limited to anterior teeth for a maximum of once per tooth;
(D) The department shall not allow a separate charge for tooth preparation, temporary restorations, cement bases, impressions, or local anesthesia;
(E) An amalgam or composite buildup shall be considered a component part of the preparation for the completed restoration except in special circumstances, and by report; and
(F) Amalgam restorations are allowed, but composite resin or acrylic restorations in posterior secondary teeth (except the facial surface of permanent first premolars) shall be considered purely cosmetic dentistry and shall not be covered;

(9) Drugs administered by the dentist in the dentist's office shall be covered at the rate of fifty cents for each drug plus the cost of the drug;

(10) Dental prosthesis limited to crowns, space maintainers, partial or full dentures, adjustments and repair, subject to the following limitations:
(A) Partial dentures shall be limited to fill the space due to the loss of one or more anterior teeth and to fill the space due to the loss of two or more posterior teeth exclusive of third molars;
(B) One partial or full denture shall be allowed per arch per recipient in any five year period. This is allowed when existing dentures cannot be repaired or adjusted;
(C) Temporary partial dentures shall be allowed only when teeth have been

extracted recently and shall be subject to the maximum benefits for dentures;

(D) Denture relines are limited to one per denture every two years;

(E) Precious, semi-precious, and non-precious metal cast crowns shall not be covered;

(F) Overdentures shall not be covered; and

(G) Space maintainers are limited to children age fourteen and under to hold the space for the eruption of the permanent cuspids, pre-molars or first molars due to premature loss of the deciduous predecessor; and

(11) Consultation and dental surgery with the following limitations:

(A) Routine postoperative visits shall be considered part of the total surgical procedure and shall not be separately compensable; and

(B) Vestibuloplastys, skin grafts, bone grafts, and implants shall not be covered except when one or more is part of the treatment for fractured jaws.

(c) Specific dental services not covered by the department shall include the following:

(1) Orthodontic services except following repair of a cleft palate or other severe developmental defect or injury in a child for which the functions of speech, swallowing, or chewing shall be restored;

(2) Fixed bridge work;

(3) Plaque control;

(4) Gold crowns and gold inlays; and

(5) Procedures, appliances, or restorations solely for cosmetic purposes.

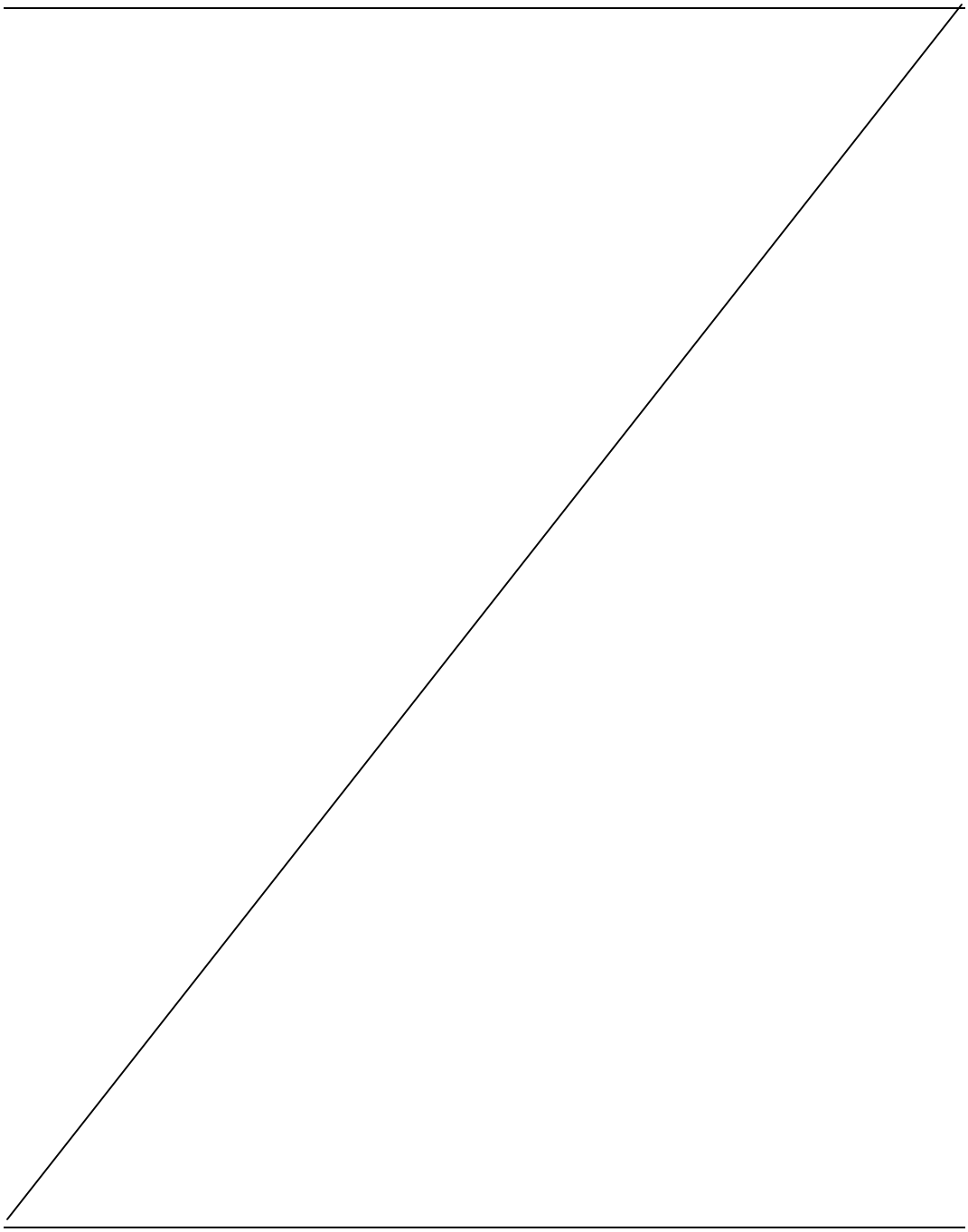
(d) Dental services for individuals twenty-one years and older are limited to emergency treatment which does not include services aimed at restoring and replacing teeth and shall include services for the following:

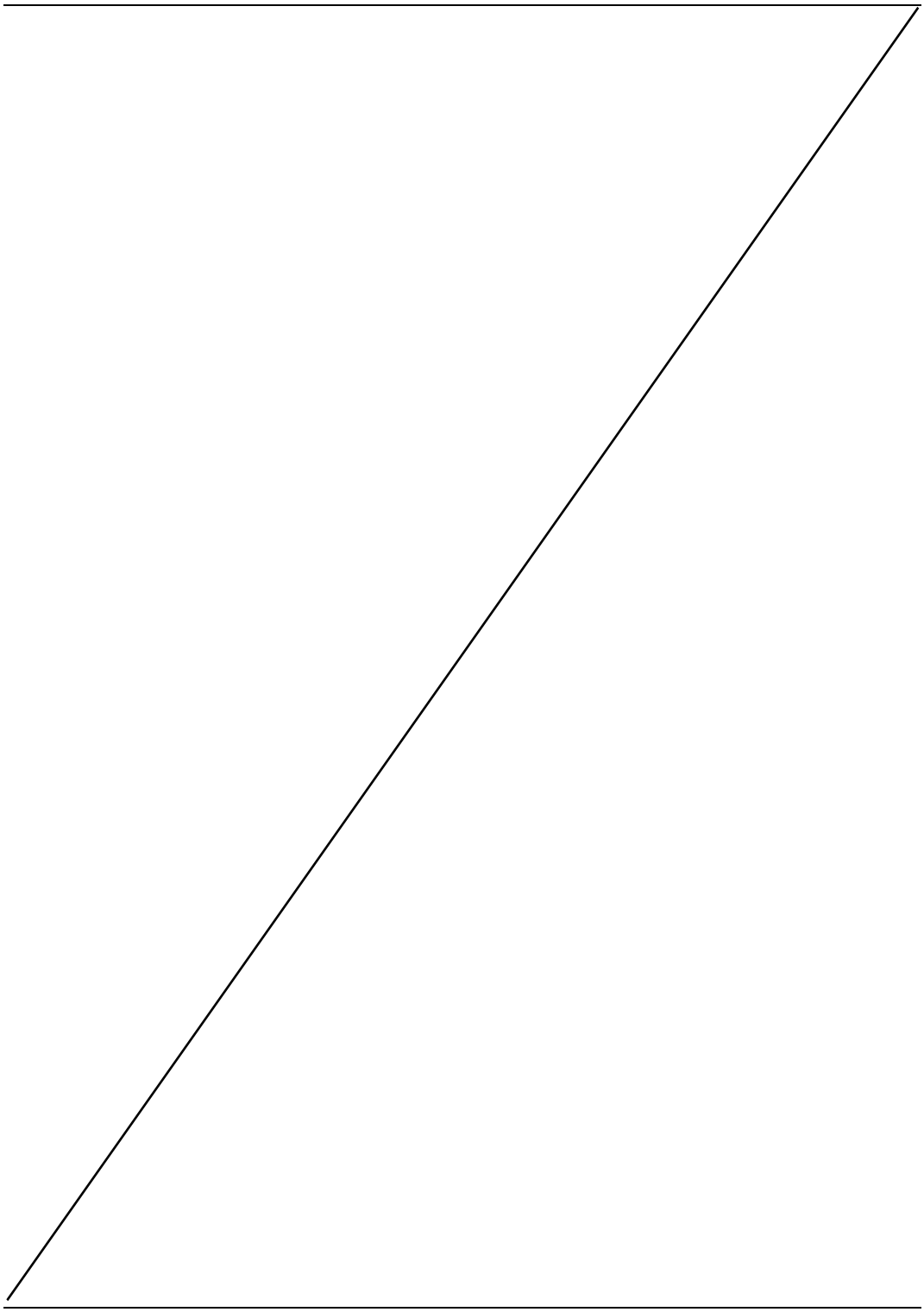
(1) Relief of dental pain;

(2) Elimination of infection; and

(3) Treatment of acute injuries to the teeth or supporting structures of the oro-facial complex. [Eff 08/01/94; am 01/29/96; am 03/30/96; am 06/19/00] (Auth: HRS §346-14) (Imp: 42 C.F.R. §440.100)

§17-1737-76 Visual services. (a) Visual or optometric services means services provided by an ophthalmologist or optometrist licensed to practice under state law to correct visual problems within the





limits of their professional fields and includes the dispensing of prescription eyeglasses on the written prescription of a licensed practitioner.

(b) Visual services shall include:

(1) Professional services limited to:

(A) Eye examinations;

(B) Refraction, with coverage of a second refraction for persons under the age of eighteen years within twelve months, or eighteen years or older within twenty-four months only when indicated by symptoms. The provider shall make a reasonable effort to determine the date of any previous refraction; and

(C) Vision analysis;

(2) Prescription eyeglasses:

(A) When, for single vision lenses, the refractive correction is at least:

(i) For an original prescription, (+) or (-) 0.50 diopter, sphere or cylinder, or 1 vertical or 5 horizontal prism diopters; or

(ii) For a change in prescription of (+) or (-) 0.50 diopter, or sphere or cylinder, or 6 degrees in cylinder axis;

(B) Which may have single vision, bifocal, or prism lenses made of glass or plastic. Glass lenses shall conform to standard Z-80 (National Bureau of Standards) as it existed on September 15, 1983;

(C) But, exclusions shall be that:

(i) Trifocal lenses shall be covered only for those persons who are currently wearing these lenses satisfactorily and for specific job requirements;

(ii) Tinted or coated corrective lenses shall be included only for persons with aphakia, albinism, glaucoma, or other medical conditions of the eyes exclusive of photophobia not associated with such conditions. Lights transmission shall be adequate to permit use of the lenses indoors and at night;

(iii) Oversize lenses shall not be

covered; and

(iv) Bilateral plano glasses shall be covered as safety glasses for persons with one remaining functioning eye;

(D) Along with the case and frame, and repair or replacement of any part;

(E) Individuals with presbyopia who require no or minimal distance correction shall be fitted with ready-made half glasses instead of bifocals; and

(F) Where applicable following cataract extraction with or without insertion of an intraocular prosthetic lens, ready-made temporary glasses shall be rented or purchased until healing has occurred and change in refractive error has stabilized;

(3) Related services which include:

(A) Verification of prescription and dispensing of eyeglasses;

(B) Fitting to include facial measurements; and

(C) Adjustment of glasses;

(4) Contact lenses of all types covered in accordance with the following limitations:

(A) Keratoconus in one or both eyes where corrected vision by glasses is less than 20/40 and the vision is further improved by contact lenses;

(B) Corneal astigmatism in one or both eyes greater than 4.00 diopter and the astigmatism correctable by contact lenses;

(C) Irregular astigmatism due to corneal imperfection where corrected vision by glasses is less than 20/40 and vision is further improved by contact lenses;

(D) Anisometropia due to aphakia or other causes where the vision corrected by glasses in the non-affected eye is less than 20/50, the problem either will last for at least six months or is permanent, and the person requires binocular vision for educational or job purposes;

(E) Bilateral aphakia when a person becomes ill using spectacle glasses or when the person's occupation makes the wearing of

glasses hazardous;

(F) Certain inflammatory conditions of the cornea for which therapeutic contact lenses are indicated with the recommendation of an ophthalmologist; and

(G) Not where there are:

(i) Elderly persons beyond the working age with aphakia where the corrected vision in the non-aphakia eye with glasses is 20/50 or better, and the addition of a contact lens will not make the person economically productive; and

(ii) Solely cosmetic purposes such as obscuring an opaque pupil;

(5) Subnormal visual aids; and

(6) Replacement of glasses or contact lenses limited to one pair or unit in a twenty-four month period.

(c) Approval shall be required to obtain contact lenses, subnormal visual aids costing more than $50, and to replace glasses or contact lenses within two years, and shall include one or more of the following:

(1) The date and circumstances of loss;

(2) The date the previous glasses were made;

(3) The visual acuity without and with correction; or

(4) The refractive prescription and the previous prescription, if a change is being requested.

(d) Bifocal lenses do not require authorization but claims for these lenses for persons under forty years of age shall include adequate medical justification.

(e) Excluded services and materials shall be:

(1) Visual training and exercise lessons;

(2) Tinted or absorptive lenses except as stated in subsection (b)(2)(C)(ii);

(3) Oversize lenses except for replacement of lenses only;

(4) Contact lenses for cosmetic purposes;

(5) Bifocal contact lenses;

(6) Blended bifocals; and

(7) All services or materials not in compliance with the preceding restrictions.

[Eff 08/01/94] (Auth: HRS §346-14) (Imp: 42 C.F.R. §§440.120, 440.230, 441.30)

§17-1737-77 Speech, hearing and language disorders. (a) Services for individuals with speech, hearing, and language disorders means diagnostic, screening, preventive, or corrective services provided by, or under the direction of, a speech pathologist or audiologist, to whom a patient is referred by a physician. Necessary supplies and equipment shall be included.

(b) A physician may prescribe services for patients with speech, hearing, or language disorders who are expected to improve in a reasonable period of time with therapy.

(c) All recommended speech, hearing, and language evaluations shall require prior authorization by the department's medical consultants according to the following procedures:

(1) For evaluation, information indicating diagnosis, age, and duration of the clinical condition; and

(2) For therapy, information indicating:

(A) The evaluation and results of standardized objective tests; and

(B) A plan of therapy with goals and time frames.

(d) If a reasonable doubt exists that an individual requires therapy or continuation of therapy, a board of experienced therapists may be asked to review the medical consultants' findings and make recommendations to the department's medical consultants. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: 42 C.F.R. §§440.110, 440.230)

§17-1737-78 Hearing evaluations and devices. (a) All hearing aid rentals, purchases, or repairs shall require medical approval by the department.

(b) Persons requesting hearing aids shall have a hearing evaluation by a physician who is an ear, nose, and throat specialist who concurs with the need for a hearing aid.

(c) The following conditions and limitations shall apply:

(1) A hearing evaluation may be permissible every twelve months;

(2) Hearing aids purchased by the medicaid program shall be of the unilateral type.

Miniaturized or "all in the ear" hearing aids are excluded. Special models or modifications shall require justification with documentation of medical necessity;

(3) Hearing aid purchase requests shall be approved initially for one month of rental at $25 per month to determine the appropriateness of the hearing aid;

(4) Purchase of the hearing aid may be recommended based on the evaluation of the rental period of paragraph (1). A new authorization form shall be submitted showing the model and serial number of the hearing aid;

(5) If the hearing aid purchase is not recommended, a factory reconditioning charge of no more than $50 may be paid when supported by a copy of the manufacturer's invoice;

(6) Repair of hearing aids shall be itemized;

(7) Hearing aid replacements may be purchased every two years with justification;

(8) Ear plugs may be purchased for individuals with recurrent middle ear infections on recommendation by a physician who is an ear, nose and throat specialist. Only one set of ear plugs every twelve months shall be allowed; and

(9) Insurance premiums to cover hearing aid losses or repair shall be a coverage only for children under twelve years of age.

(d) Eligible children may be referred to the department of health for hearing evaluations and services. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: 42 C.F.R. §§431.10, 440.110, 440.220)

§17-1737-79 Physical therapy and occupational therapy services. (a) Physical therapy means services prescribed by a physician that are provided to a recipient by a qualified physical therapist licensed by the state and certified by the medicaid program to provide services. Necessary supplies and equipment shall be included as part of this service.

(b) Occupational therapy means services prescribed by a physician provided to a recipient by a qualified occupational therapist who has been certified by the American Occupational Therapy Association and

approved by the medicaid program to provide services. Necessary supplies and equipment shall be included as part of the service.

(c) Physical and occupational therapy may be prescribed by a physician when medically necessary and when the following conditions are met:

(1) The services are considered under accepted standards of medical practice, to be a specific and effective treatment for the patient's condition;

(2) The services or patient's condition is of a level of complexity requiring services that can be safely and effectively performed only by a qualified therapist. Maintenance therapy which does not require the performance and supervision of a therapist shall be considered as nursing rather than therapy services for separate billing, even if performed or supervised by a therapist;

(3) There is an expectation that the patient's condition will improve significantly in a reasonable period of time based on the assessment made by the physician of the patient's restoration potential, or the services are necessary to establish a safe and effective maintenance program required in connection with a specific disease state; and

(4) The amount, frequency, and duration of services are reasonable.

(d) When physical therapy or occupational therapy is requested for an acute symptomatic condition without demonstrable musculoskeletal abnormality, the therapy shall be provided for only a short period of time not to exceed two weeks, except when extended by prior approval.

(e) Where a neuro-musculoskeletal abnormality is demonstrated, a definitive diagnosis shall be made utilizing radiologic or appropriate diagnostic procedures, and if necessary, specialty consultation.

(f) All recommended therapy for non-institutional recipients shall require the approval of the medical consultant and the request shall include the following information:

(1) Diagnosis;

(2) Recommended therapy indicating the frequency and estimated duration of therapy; and

(3) For chronic cases, long term goals and a plan of care.

(g) Outpatient physical therapy services and outpatient occupational therapy shall be limited to no more than three-fourths of an hour or three modalities of treatment per day although several treatment modalities may be provided during this treatment period. Physical therapy services exceeding three-fourths of an hour or three modalities shall be specifically approved by the department prior to the provision of services. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: 42 C.F.R. §§440.10, 440.230)

§17-1737-80 Podiatrist's services. (a) Podiatrists' services means services directed toward the treatment and care of feet ailments or disorders that are provided by state licensed practitioners within the scope of the practice of podiatry as defined by state law.

(b) Podiatric services and appliances (orthoses, prostheses) shall include:

(1) Professional services, not involving surgery, provided in the office and clinic; professional services, not involving surgery, related to diabetic foot care in the outpatient and inpatient hospital, skilled nursing facility, and intermediate care facility under the following conditions:

(A) The podiatrist shall be recognized as the primary provider of diagnostic and treatment services which are, in the practice of the podiatrist's profession, customarily provided in the office or in an outpatient clinic;

(B) Podiatric services, not involving surgery, in a hospital (inpatient or outpatient), skilled nursing facility, and intermediate care facility shall be considered as adjuncts to general medical care and limited to diabetic foot care;

(C) In the case of a patient requiring inpatient hospital care, podiatric services shall be limited to diabetic foot care only, must be ordered by the attending physician as noted by the physician in the medical chart, and may be furnished after obtaining prior authorization from the department's

medical consultant; and
(D) In the case of a patient requiring podiatric services in a skilled nursing or an intermediate care facility, podiatric services shall be limited to diabetic foot care only and must be ordered by the attending physician as noted by the physician in the medical chart;
(2) Surgical procedures limited to those involving the ankle and below; surgical procedures performed in the office; clinic; and skilled nursing or intermediate care facility with costs greater than $50 require prior authorization from the department's medical consultant. All surgical procedures performed in the outpatient hospital require prior authorization from the department's medical consultants;
(3) Diagnostic radiology procedures limited to the ankle and below;
(4) Foot appliances (orthoses, prostheses);
(5) Orthopedic shoes and casts; and
(6) Orthodigital prostheses and casts.

(c) The following services shall not be covered under the program:
(1) Routine foot care, including debridement not related to treatment of infection or injury; and
(2) Treatment of flat feet.

(d) All podiatric services to be provided to a hospital inpatient or recommended appliances of a non-emergency nature and costing more than $50 shall require prior approval of the department. Requests for services or appliances shall be submitted on the appropriate departmental form by the patient's attending physician. [Eff 08/01/94; am 01/29/96] (Auth: HRS §346-14) (Imp: 42 C.F.R. §440.60)

§17-1737-81 Pediatric or family nurse practitioner services. (a) Pediatric or family nurse practitioners are registered nurses who meet the following conditions:
(1) Licensed to practice as a registered professional nurse in the State;

(2) Successfully completed an accredited, advanced training program in pediatrics or family health; and

(3) Currently certified by the American Nurses Association or the National Board of Pediatric Nurse Practitioners and Nurses to practice in either specialty named above.

(b) Nurse practitioner services to medicaid recipients shall be limited to the scope of practice a nurse practitioner is legally authorized to perform under state law at locations including, but not limited to:

(1) The practitioner's office;

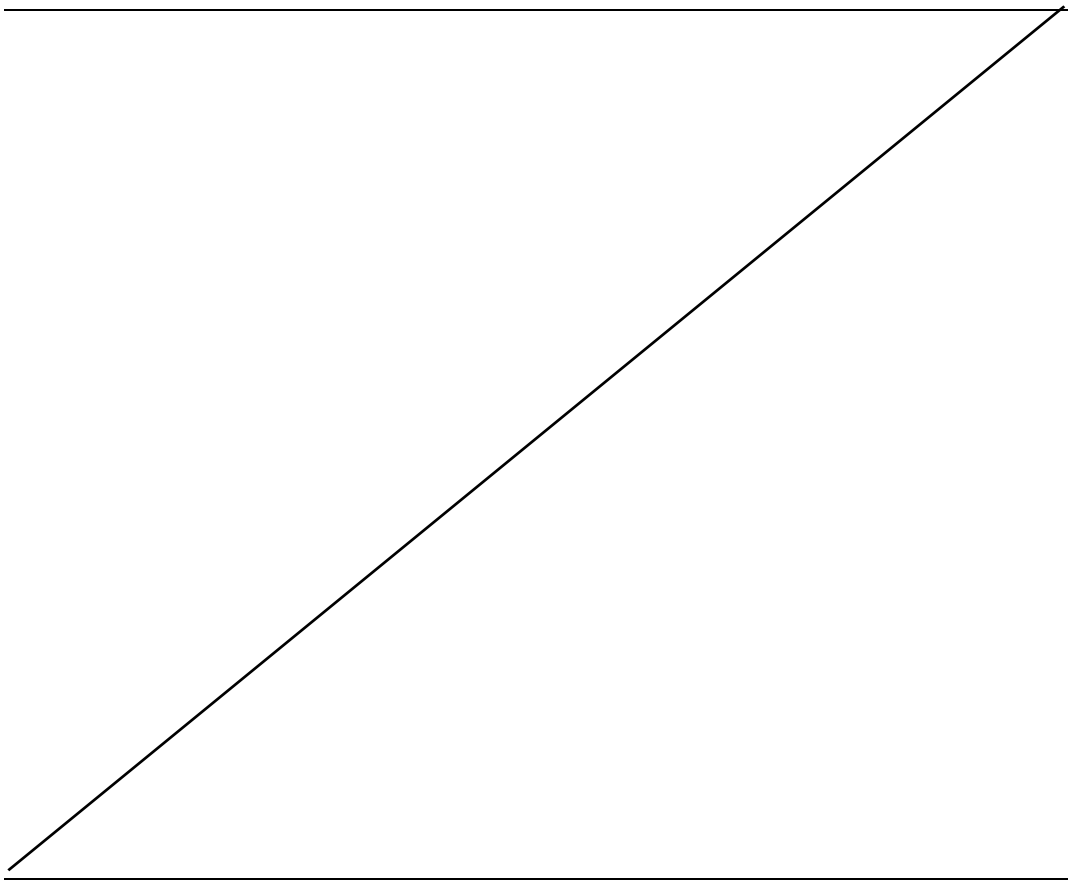
(2) A private or public clinic;

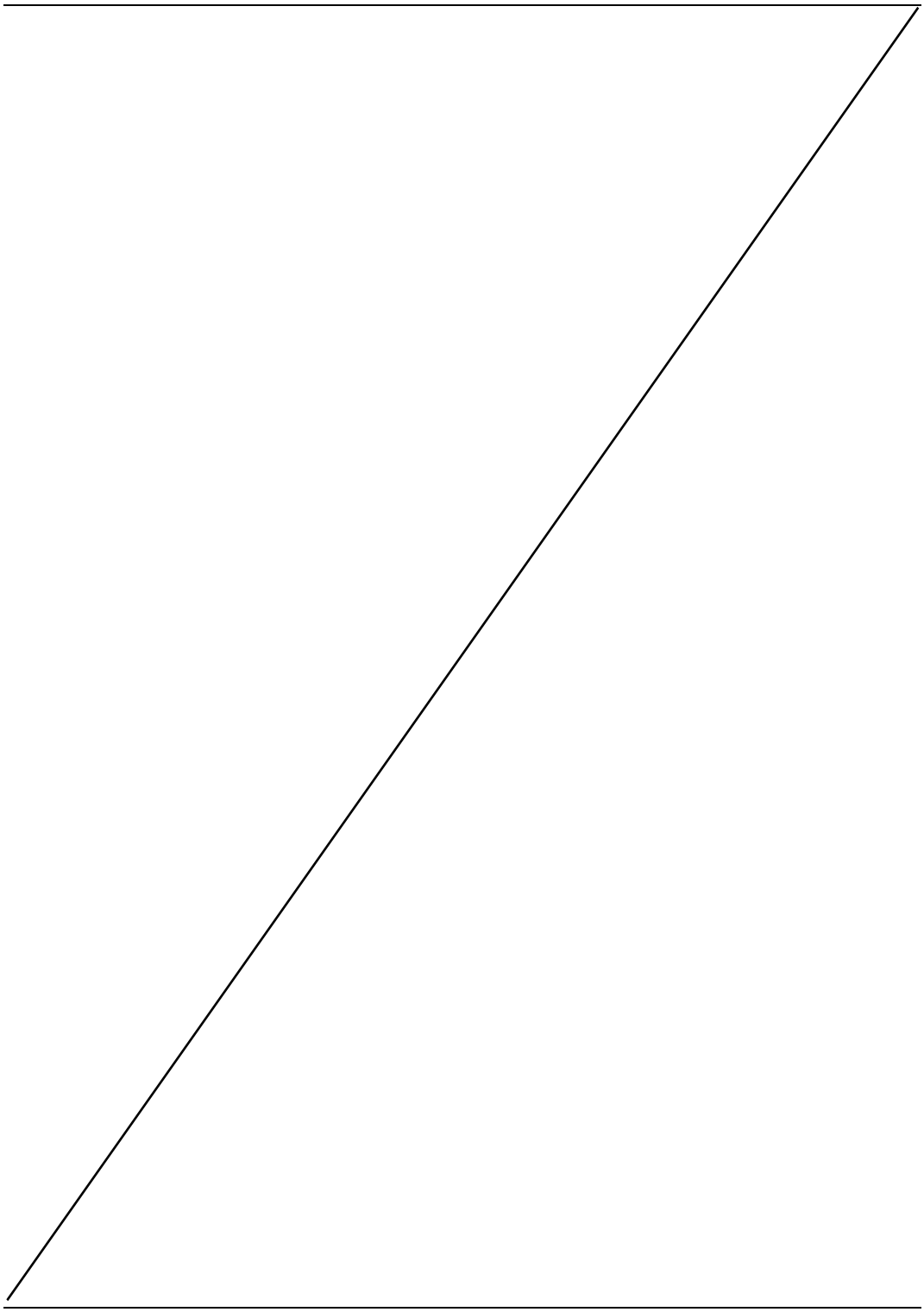
(3) A private home;

(4) An approved hospital;

(5) An approved nursing facility; or

(6) A licensed care home or adult family boarding home.





(c) Medicaid payments shall be made only to pediatric and family nurse practitioners who meet the requirements of this section and of chapter 17-1736. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: Pub. L. No. 101-239, §6405)

§17-1737-82 Intra-state transportation. (a) Transportation may be provided in order to enable a recipient to secure needed medical care and related services.

(b) Transportation shall be by the most economical means which would not be hazardous or injurious to the recipient's health.

(c) Air transportation may be allowable where the attending physician or a hospital refers a recipient to a specialist or medical facility for diagnostic and treatment services not available or not accessible on the recipient's island of residence. Air transportation requests may be initiated by the department's social worker when a physician is not available to refer an individual for medical care in Honolulu.

(d) In emergency situations, air transportation:

(1) Shall be by regularly scheduled commercial flight when:

(A) Available;

(B) Medical care will not be affected if travel is delayed until the next scheduled flight; and

(C) The patient can sit in a standard seat and requires no oxygen or other life support mechanisms enroute; or

(D) If the patient is unable to sit and a stretcher is required, the airline may accommodate the patient in lieu of four passenger seats;

(2) Shall be by air ambulance service when:

(A) Regularly scheduled commercial flights are inappropriate because of problems with the recipient's condition, which include:

(i) Head injuries with evidence of increasing intracranial pressure;

(ii) Multiple system injuries;

(iii) Complications of labor or prematurity of newborn children with respiratory distress; or

(iv) Other acute injuries or illnesses

beyond local capabilities; and do not allow for service or time delays; or

(B) Recipients to be transported on an arranged basis cannot travel by regularly scheduled commercial flights because the recipients are:

(i) In spica casts returning home to another island; or

(ii) Long-term care patients who are bed-bound and going to another island;

(3) If by air ambulance:

(A) Shall be authorized for a one-way trip only; and

(B) Shall have life support services and at least one attendant on the flight;

(4) Shall be arranged by the recipient's attending physician or hospital who shall complete and sign the appropriate form justifying the use of an air ambulance and give the original and all copies of the form to the air ambulance crew chief; and

(5) May be coordinated with surface ambulance service by the referring physician to the designated hospital on the island of destination.

(e) In a non-emergency situation, air transportation:

(1) Shall be subject to prior review and authorization by the department's medical consultant;

(2) May be provided in the form of a round-trip ticket when medical services on another island are recommended by the attending physician and the recipient is expected to return home in two weeks or less;

(3) May be provided in the form of a round-trip ticket to a person accompanying the recipient if an attendant's service is recommended by the commercial carrier. Payment may be made for an attendant's services when rendered by a person other than a relative under section 17-1739-7; and

(4) Shall be by regularly scheduled commercial flights.

(f) In both emergency and non-emergency situations, the department shall allow other related inter-island travel expenses, such as:

(1) Cost of outside meals and lodging, while receiving necessary and authorized medical services; and

(2) Vendor payments for meals and lodging made only to designated providers of the services who have been authorized to participate under the department's medical assistance program.

(g) Ground ambulance service may be allowed as follows:

(1) Emergency ambulance service for injuries shall be available in each county to the patient. Ambulance service may be used in an emergency; and

(2) Ambulance transfer service for transporting a recipient to, from, and between medical facilities and other providers may be utilized when recommended by the attending physician.

(h) Taxi service may be allowed as follows:

(1) Transportation by taxi may be authorized by the payment worker to assist a recipient to obtain covered medical services where:

(A) A recipient resides in an area not served by a bus system;

(B) A recipient has no means of transportation;

(C) Transportation is available but the recipient cannot be accommodated at a suitable hour; or

(D) A recipient is acutely ill, injured or has a physical or mental impairment verified by a physician, and travel by bus would be either hazardous to that person's health or would cause physical hardship; and

(2) For rural areas, available taxi service nearest to the recipient's home shall be utilized.

(3) The department shall not be required to provide transportation beyond the closest geographic area where appropriate health care services are readily available.

(i) Handicab services may be used for recipients who are confined to a wheelchair or who are physically unable to take care of themselves. [Eff 08/01/94; am 02/10/97] (Auth: HRS §346-14) (Imp: 42 C.F.R. §440.170)

§17-1737-83 Out-of-state transportation. (a) Out-of-state transportation may be provided to eligible recipients for covered medical services which are unavailable in Hawaii and with prior authorization by the department's medical consultant.

(b) Transportation shall be by the most economical means which would not be hazardous or injurious to the recipient's health.

(c) Transportation shall be limited to a United States medical facility which is licensed to provide such services and certified as a medicaid provider by the state where the facility is located.

(d) Request for out-of-state transportation shall be made by the attending physician or a medical facility and shall include:

(1) All information requested in the department designated forms; and

(2) A comprehensive clinical summary of the patient's condition, need for out-of-state medical facility service, the name and address of the out-of-state facility and the name and telephone number of the authorized representative of that medical facility.

(e) Out-of-state transportation may be provided in the form of a round trip ticket issued to:

(1) The recipient when the recipient is expected to return home in thirty days or less as determined by the attending physician or medical facility. A one-way ticket may be issued when the recipient is expected to remain out-of-state for more than thirty days.

(2) Any person accompanying the recipient without regard to the person's relationship to the recipient, if an attendant is required by the transportation carrier or recommended by the attending physician or the medical facility and authorized by the department's medical consultant.

(f) Other related travel expenses may be allowed with prior authorization by the department's medical consultant and may include but not be limited to:

(1) Cost of meals and lodging for the recipient and one attendant;

(2) Taxi or other non-emergency ground transportation when such transportation is related to the provision of authorized medical coverage; and

(3) Services of an attendant provided the attendant is unrelated to the recipient. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 C.F.R. §§431.53, 440.170)

§17-1737-83.1 Out-of-state medical services. (a) Out-of-state medical services shall be covered for eligible Hawaii residents visiting in another state. Medical services incurred while visiting in another state shall be covered only when the requirements of temporary absence as stated in section 17-1714-22(d) are met.

(1) To receive payment for services incurred out-of-state, the provider shall meet the requirements of section 17-1736-13. In addition:
   (A) The services were required as they were an emergency;
   (B) The services were needed and the recipient's health would have been endangered if the recipient had to return to the State of residence; or
   (C) The State has determined that the services sought are unavailable in Hawaii or more readily available in another state; or
(2) Out-of-state Services shall require prior authorization by the department, with the exception to the services indicated in subsection (b), paragraphs (1) and (2).

(b) Children under the age of nineteen and children under the age of twenty-one years who are in foster care placement or are covered by subsidized adoption agreements shall be eligible for out-of-state medical services. [Eff 02/10/97] (Auth: HRS §346-14) (Imp: 42 C.F.R. §§430(a); 431.52)

§17-1737-84 Exclusions and limitations. (a) Medical assistance payments shall not be made for certain health services or items for reasons including, but not limited to the following:

(1) The procedure, service, or material is of generally unproven benefit;
(2) It is of an experimental nature;

(3) It is excluded by federal regulations or state rules;
(4) It is not considered by the department to be medically necessary;
(5) The same or similar results may be obtained by another method at a reduced cost;
(6) The procedure is frequently followed by severe complications which may be in themselves life-threatening or require prolonged medical care or secondary operations; or
(7) Prior authorization is required but has not been obtained.

(b) Based on subsection (a), the following procedures or services are excluded and the medical assistance program shall not pay any services in association with them:
(1) Drugs not approved by the U.S. Food and Drug Administration;
(2) Long term psychiatric institutional treatment;
(3) Treatment of a person confined to a public institution regardless of where the treatment is performed;
(4) The follow-up examination or treatment of Hansen's disease after the diagnosis has been established regardless of whether the patient is contagious except for surgical or rehabilitative procedures to restore useful function;
(5) Treatment for tuberculosis when such treatment is available free to the general public;
(6) Acupuncture;
(7) Naturopathic, chiropractic, or Christian Science or faith healing services;
(8) Private duty nursing;
(9) Circumcision after twelve months of age unless there is documentation of phimosis severe enough to prevent retraction, recurrent balanitis, severe verrucae of or under the prepuce or severe adhesions between glans and prepuce;
(10) Repair of umbilical or ventral herniae unless they are painful or bowel is present in the sac;
(11) Excision or destruction of benign skin or subcutaneous lesions except hemangiomas,

plantar warts, molluscum contagiosum, leukiplakia or milia without medical justification;

(12) Hysterectomies and sterilization procedures not complying with the restrictions under sections 17-1737-47 and 17-1737-48;

(13) Reversal of elective sterilization procedures;

(14) Rhinoplasties except following accidental injury resulting in significant obstruction of breathing;

(15) Gastroplasty or other surgical procedures on the stomach or bowel, or both, when performed for morbid obesity unless the operation may logically be expected to improve an established medical condition such as cardiac or respiratory decompensation or severe hypertension. Guidelines issued by the department shall be met;

(16) Orthodontic services except for the provisions of section 17-1737-75(c)(1) and fixed bridgework;

(17) Orthoptic training;

(18) Tinted and contact lenses except as described under section 17-1737-76 (visual services);

(19) Personal comfort items such as radios, televisions, telephones, fans, or air conditioners;

(20) Standard household items such as beds, linens, cooking utensils, or blenders;

(21) Cosmetic, reconstructive, or plastic surgery performed primarily to improve or change physical appearance, performed primarily for psychological purposes, or to restore form but which does not correct or materially improve bodily function. However, consideration may be given when the purpose of the procedure is to:

(A) Correct a congenital anomaly;

(B) Restore body form following an accidental injury; or

(C) Revise disfigurement or extensive scars, or both, resulting from neoplastic surgery;

(22) Specific cosmetic surgery procedures including:

(A) Sex transformation treatments, procedures, hormones, or other

medication for the establishment or maintenance of gender reassignment except that medication may be allowed if the sex of the individual has been changed by court order;

(B) Cosmetic, reconstructive, or plastic surgery procedures performed primarily for psychological reasons or as a result of the aging process;

(C) Augmentation mammoplasties except following medically indicated mastectomies for carcinoma, precancerous conditions, or extensive fibrosis or traumatic amputation;

(D) Reduction mammoplasties unless there is medical documentation of intractable pain not amenable to other forms of treatment as a result of increasingly large pendulous breasts;

(E) Paniculectomies and other body sculpturing procedures;

(F) Removal of tattoos;

(G) Hair transplants;

(H) Electrolysis;

(I) Insertion of testicular prostheses, unilateral or bilateral;

(J) Jejuno-ileal by-pass procedures for morbid obesity;

(K) Ear piercing;

(23) In vitro fertilization procedures;

(24) Medications, devices, or agents for the treatment of erectile dysfunction in males; and

(25) Swimming lessons, summer camp, gym membership, weight control classes, or smoking cessation classes.

(c) The UCC shall apply these exclusions in facilities and for recipients under its review. In other cases authorization of the department shall be obtained before performing any of the above procedures where exclusions are allowed.

(d) All other forms or types of health care services and supplies not specifically mentioned in this chapter shall not be included in the program. Questions regarding a form or type of health care service or supply shall be directed to the medical consultant.

(e) New tests, procedures, equipment, supplies, and other services for which payment has not been

claimed previously shall not be considered for inclusion until information satisfactory and acceptable to the program has been received and approval given. This particularly applies to tests and procedures not included in the HCPCS code, where several procedures are being clumped under one heading, or a single procedure is divided into several components. [Eff 08/01/94; am 03/30/96; am 11/25/96; am 02/10/97; am 07/06/99; am 06/19/00] (Auth: HRS §346-14) (Imp: 42 C.F.R. §456.3)

§§17-1737-85 to 17-1737-89 (Reserved).

SUBCHAPTER 8

TISSUE AND ORGAN TRANSPLANTATION

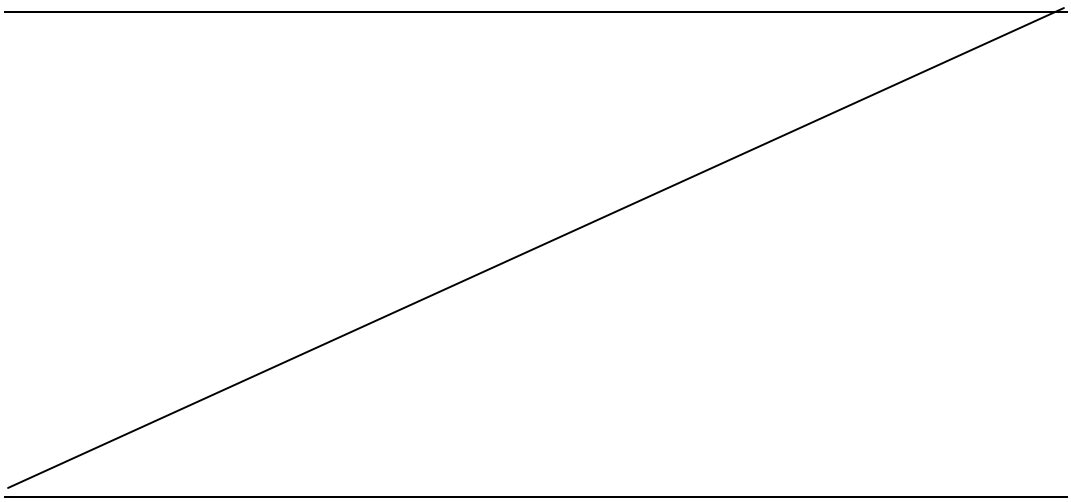
§17-1737-90 Definitions. As used in this subchapter:

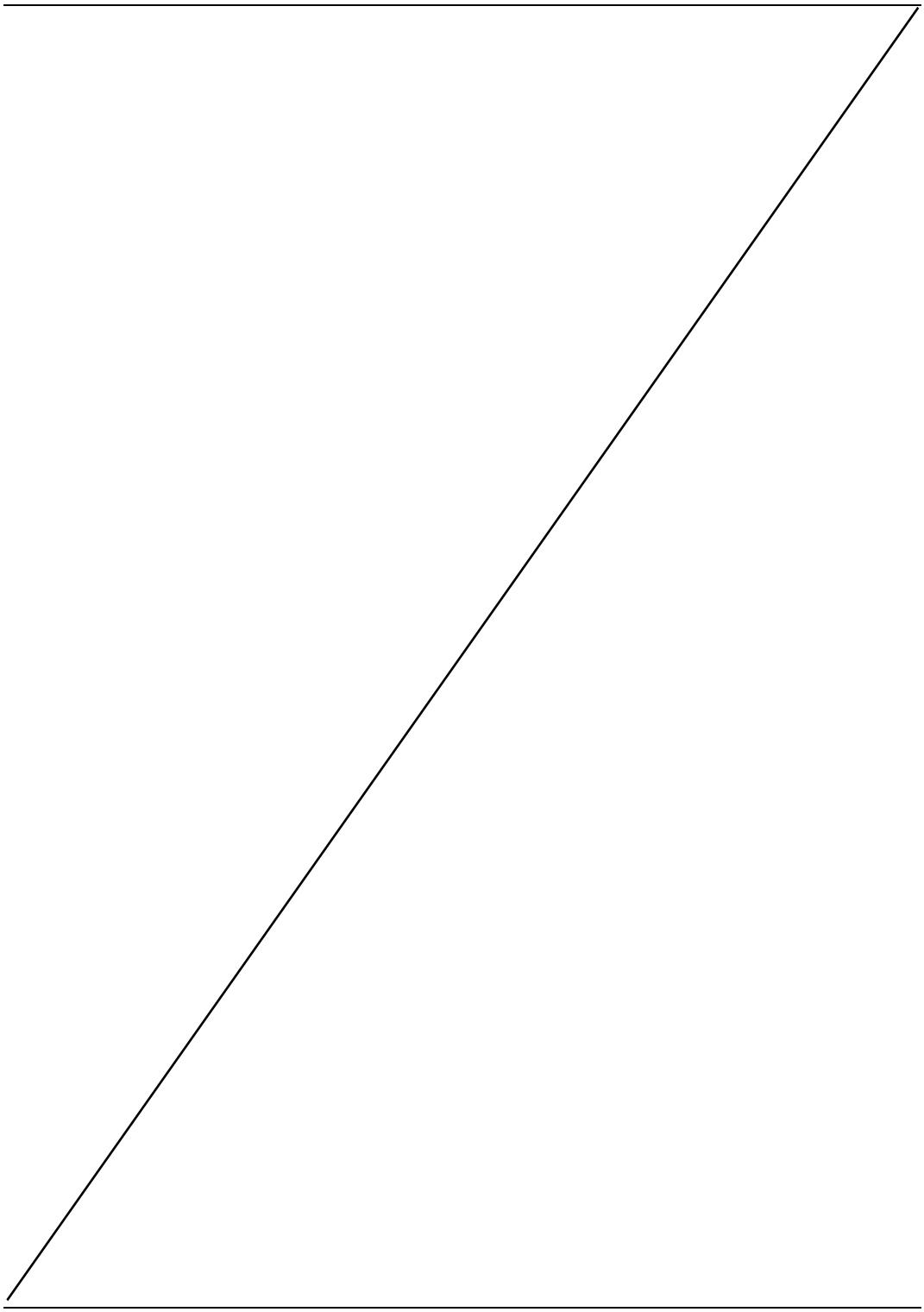
"Allogenic" organ or tissue means the source of the organ or tissue is from another person.

"Antigen" means any substance which is capable under appropriate conditions of inducing a specific immune response.

"Autologous bone marrow" is bone marrow obtained from the patient and stored for subsequent infusion.

"Cadaveric" tissue or organ is tissue or organ removed from a donor who has irreversible brain damage and who has been declared brain dead. The donor may





have been maintained by artificial means for harvesting of the tissue or organ or the donor may have died and the tissue or organ was removed prior to its deterioration.

"Histocompatibility" is the matching of the tissue so the graft will not be rejected due to the presence of incompatible antigens.

"Organ" is a somewhat independent part of the body that performs a special function or functions.

"Tissue" means an aggregation of similarly specialized cells united in the performance of a particular function.

"Transplantation" means the grafting of organs and tissues taken from the patient's own body or from another for the purpose of replacing diseased tissues or diseased organ. [Eff 08/01/94; am 11/25/96] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 C.F.R. §440.230; 42 U.S.C. §1396(b)(i))

§17-1737-91 General provisions. (a) Allogenic bone marrow and cadaveric corneal transplants are covered under this program.

(b) Kidney transplantations are covered under this program.

(c) Other non-experimental, non-investigational organ and tissue transplantations are covered when performed in a facility certified by Medicare for the specific transplantation and approved for medical necessity by the department's medical consultant.

(d) Transplantation shall be performed by experienced specialists with transplantation training and with established success records in an approved Medicare-certified facility with proper equipment and adequate and appropriately trained support staff, except as provided in subsection (i).

(e) Prior authorization shall be required from the department's medical consultant for all transplants.

(f) Immunosuppressive therapy shall be covered as required.

(g) If a transplant should fail or be rejected and the patient is still within the age limits for transplantation, the program's medical consultant may review the case for one additional transplantation for that patient.

(h) The program shall cover costs of tissue typing of potential donors and cost of acquisition of

the tissue or organ as well as other studies necessary to determine the appropriateness of the procedure and any post transplantation follow-up evaluations as required.

(i) When approved by the department's medical consultant, a patient may be treated at an appropriate out-of-state Medicare-certified transplant center for the authorized procedure. [Eff 08/01/94; am 11/25/96] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 C.F.R. §440.230; 42 U.S.C. §1396b(i))

§17-1737-92 Corneal transplant (keratoplasty).

(a) Indications of penetrating keratoplasty include:

(1) Corneal opacification that sufficiently obscures visibility (vision) through the anterior segment of the eye with at least light perception present. Causes for this problem include:

(A) Corneal injury and scarring;

(B) Corneal degeneration (from Fuch's or other dystrophy or from previous cataract or intraocular lens implantation, or both);

(C) Corneal degeneration from keratoconus or familial causes;

(D) Corneal infection (e.g., herpes); and

(2) Therapeutic graft for relief of pain with at least light perception vision present, from corneal degeneration because of inflammation with pain in the eye and useful vision still present.

(b) Indications of lemellar keratoplasty include:

(1) Superficial layer corneal scarring and deformity due to:

(A) Trauma;

(B) Degeneration;

(C) Infection; or

(D) Congenital deformity (anterior);

(2) Aphakia;

(3) High myopia;

(4) High refractive error;
(5) Keratoconus; and
(6) Recurrent pterygium.

(c) Conditions and limitations affecting corneal transplant include:

(1) A relative contraindication is intractable glaucoma in the eye under consideration for surgery;
(2) No active eye infection at the time of surgery;
(3) No general medical contraindications to surgery or anesthesia;
(4) Informed consent shall be obtained from the patient or patient's representative; and
(5) No age restriction. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 C.F.R. §440.230; 42 U.S.C. §1396b(i))

§17-1737-93 Allogenic bone marrow transplant. (a) Indications for allogenic bone marrow transplant include:

(1) Severe aplastic anemia unresponsive to usual therapy;
(2) Acute myelogenous leukemia in first remission;
(3) Acute lymphocytic leukemia in second remission; and
(4) Chronic leukemia after first year.

(b) Conditions and limitations affecting allogenic bone marrow transplant include:

(1) Human leukocyte group A (HLA) histocompatible donor shall be available;
(2) Patient has no other major systemic disease which would result in poor potential for recovery (such as a heart condition, liver disease, kidney damage, brain lesions, cancer in other organs or lung disease);
(3) Patient shall have been properly evaluated by a qualified authority in Hawaii and bone marrow transplant is recommended as a possible curative procedure or if palliative, with reasonable likelihood for prolongation of life and return to an active life;
(4) No active infection at the time of the procedure;
(5) No general medical contraindication for the procedure and anesthesia;

(6) Informed consent shall be obtained from the patient or the patient's representative; and
(7) Age restricted to fifty or under except when identical twin is histocompatible and then age limit may be fifty-five.
[Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 C.F.R. §440.230; 42 U.S.C. §1396b(i))

§17-1737-94 Kidney transplant. (a) Indications are irreversible kidney failure that has progressed to a point that a useful, comfortable life can no longer be sustained by conventional medical treatment. The following conditions may deteriorate to the point when kidney transplant may be required:
(1) Glomerulonephritis:
(A) Proliferative;
(B) Membranous;
(C) Mesangio-capilliary;
(2) Chronic pyelonephritis;
(3) Hereditary:
(A) Polycystic disease;
(B) Medullary cystic disease;
(C) Nephritis (including Alport's syndrome);
(4) Hypertensive nephrosclerosis;
(5) Metabolic:
(A) Cystinosis;
(B) Amyloid;
(C) Gout;
(6) Congenital:
(A) Hyperplasia;
(B) Horseshoe kidney;
(7) Toxic:
(A) Analgesic nephropathy;
(B) Heavy metal poisoning;
(8) Irreversible acute renal failure:
(A) Cortical necrosis;
(B) Acute tubular necrosis; and
(9) Trauma.
(b) Conditions and limitations affecting kidney transplant include:
(1) A living, related donor with major blood group (ABO) and human leukocyte group A (HLA) histocompatibility, or an appropriate cadaveric kidney with major blood group (ABO) and human leukocyte group A (HLA) histocompatibility shall be available;

(2) Patient shall be in a stable emotional state;
(3) There is no active infection at the time of transplant;
(4) There are no general medical contraindications to major surgery and anesthesia;
(5) Patient has a normal lower urinary tract;
(6) There are no other major systemic disease which would preclude successful recovery potential (such as cancer, polyarteritis, systemic lupus erythematosis or heart, lung or liver disease);
(7) Patient is evaluated by a qualified authority in Hawaii and renal transplant is recommended;
(8) Informed consent shall be obtained from the patient or the patient's representative; and
(9) Age limits five through fifty.

[Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 C.F.R. §440.230; 42 U.S.C. §1396b(i))

§§17-1737-95 to 17-1737-99 (Reserved).

SUBCHAPTER 9

HOSPICE SERVICE

§17-1737-100 Definitions. As used in this subchapter:

"Attending physician" means a physician (M.D.) or a doctor of osteopathy (O.D.) who is identified by the individual, at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of the individual's medical care.

"Hospice program" means a public or private organization or subdivision of either, that is primarily engaged in providing care to terminally ill individuals and is qualified as a medicaid provider.

"Periods of crisis" is a period in which the individual requires continuous care to achieve palliation or management of acute medical symptoms.

"Representative" means a person who is, because of the individual's mental or physical incapacity,

authorized in accordance with state law to execute or revoke an election for hospice care or terminate medical care on behalf of the terminally ill individual.

"Respite care" is short term inpatient care provided to the individual only when necessary to relieve the family members or other persons caring for the individual.

"Terminally ill" means that the individual has a medical prognosis that the individual's life expectancy is six months or less. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: 42 U.S.C. §1396(a) and (d))

§17-1737-101 Hospice care. (a) Hospice care means care and services provided to a terminally ill individual by a hospice program in home, outpatient and inpatient settings.

(b) The hospice shall retain professional management responsibility for services related to the terminal illness and shall ensure that they are furnished in a safe and effective manner by persons qualified to provide services, and in accordance with a plan of care as specified in section 17-1737-102.

(c) Hospice services shall be provided by hospice employees or by staff contracted by the hospice and includes the following:

(1) Nursing care and services by or under the supervision of a registered nurse;
(2) Medical social services provided by a qualified social worker under the direction of a physician;
(3) Physician services provided by physician employees of the hospice including physician members of the interdisciplinary team;
(4) Counseling services available to both the individual and the family including the following:
    (A) Dietary, spiritual and any other counseling services for the individual and family while enrolled in the hospice; and
    (B) Bereavement counseling, provided after the patient's death;
(5) Physical therapy services, occupational therapy services, and speech-language pathology services;
(6) Home health aide and homemaker services to

meet the needs of the patients;

(7) Medical supplies and appliances including drugs and biologicals, provided as needed for the palliation and management of the terminal illness and related conditions; and

(8) Inpatient care for pain control and symptom management provided in a participating medicaid facility.

(d) Hospice care shall be limited to two periods of ninety days each and one subsequent period of thirty days during the individual's lifetime.

[Eff 08/01/94] (Auth: HRS §346-14) (Imp: 42 U.S.C. §1396(a) and (d))

§17-1737-102 Plan of care. (a) A written plan of care shall be established and maintained for each individual admitted to a hospice program and the care provided to an individual shall be in accordance with the plan.

(b) The plan shall be established by the attending physician, medical director or physician designee and interdisciplinary group prior to providing care.

(c) The plan shall be reviewed and updated by the attending physician, the medical director, and interdisciplinary group at intervals, as specified in the plan.

(d) The plan shall include all of the following:

(1) Assessment of the individual's needs;

(2) Identification of the services including the management of discomfort and symptom relief; and

(3) Statement in detail of the scope and frequency of services needed to meet the patient's and family's needs.

[Eff 08/01/94] (Auth: HRS §346-14) (Imp: 42 U.S.C. §1396(a) and (d))

§17-1737-103 Eligibility for hospice care. (a) Hospice care shall be provided to eligible applicants and recipients of medical assistance who voluntarily elect hospice care in lieu of medicaid services which relate to the individual's terminal illness or a related condition, or which are duplicative of hospice services.

(b) All of the following conditions shall be met:

(1) A written certification of terminal illness is obtained by the hospice, signed by the hospice physician and the individual's attending physician;
(2) The recipient or a representative voluntarily elects to participate in the medicaid hospice program and signs the appropriate medicaid form requesting this service; and
(3) Approval is obtained from the department on a designated form. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: 42 U.S.C. §1396(a) and (d))

§17-1737-104 Election of hospice care. (a) An eligible individual who elects to receive hospice care shall file an election statement with the hospice. A representative may also file an election statement.

(b) An election to receive hospice care shall be considered to continue through the initial ninety day period and subsequent ninety and thirty day election periods without a break in care if the individual:

(1) Remains in the care of the hospice; and
(2) Does not revoke the election of hospice care.

(c) Additional days of hospice care beyond the two hundred ten days stipulated in subsection (b) may be allowed if the personal or hospice physician recertifies the individual to be terminally ill.

(d) An individual or representative may designate an effective date for the election of hospice care beginning with the first day of hospice care but no earlier than the date the election is made.

(e) Individuals electing hospice care who are eligible for both medicare and medicaid shall have their hospice election periods counted concurrently.

(f) Individuals who have private insurance coverage for hospice care shall utilize that resource before medicaid coverage. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: 42 U.S.C. §1396(a) and (d))

§17-1737-105 Waiver of other medicaid benefits. (a) An individual who elects hospice services shall waive all rights to medicaid payments for services related to the treatment of the terminal condition for which hospice care was elected or a related condition or that are equivalent to hospice care.

(b) Medicaid payments may be made for hospice and

related services provided by:

(1) The designated hospice;

(2) Another hospice under arrangements made by the designated hospice; and

(3) The individual's attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for services to the individual.

(c) Medicaid payments may be made for other medicaid covered services unrelated to the terminal condition for which hospice care was elected. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: 42 U.S.C. §1396(a) and (d))

§17-1737-106 Revoking the election of hospice. (a) An individual or representative may revoke an election of hospice care at any time during an election period.

(b) The individual or representative shall file a signed statement with the hospice that revokes medicaid coverage of hospice care and the effective date of the revocation.

(c) The individual or representative may at any time elect to again receive hospice care for any other hospice election period the individual is eligible to receive. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: 42 U.S.C. §1396(a) and (d))

§17-1737-107 Payment for hospice care. (a) Payments shall be available to medicaid certified providers for hospice care as provided for under this subchapter.

(b) Payment for hospice care shall be made in the same amounts and using the same methodology as the medicare program.

(c) The following categories shall be utilized to determine payment:

(1) Routine home care day. A routine home care day is a day on which an individual who has elected to receive hospice care is at home and is not receiving continuous care as defined in paragraph (2);

(2) Continuous home care day. A continuous home care day is a day on which an individual who has elected to receive hospice care is not in

an inpatient facility and receives hospice care consisting predominantly of nursing care on a continuous basis at home. Home health aide or homemaker services or both may also be provided on a continuous basis. Continuous home care is furnished during periods of crisis and only as necessary to maintain the terminally ill patient at home. A minimum of eight hours of care shall be required to qualify for the continuous home care rate;

(3) Inpatient respite care day. An inpatient respite care day is a day on which the individual who has elected hospice care receives care in an approved facility on a short-term basis for respite. Respite care may not be reimbursed for more than five consecutive days at a time; and

(4) General inpatient care day. A general inpatient care day is a day on which an individual who has elected hospice care receives general inpatient care in an inpatient facility for pain control or acute or chronic symptom management which cannot be managed in other settings.

[Eff 08/01/94] (Auth: HRS §346-14) (Imp: 42 U.S.C. §1396(a) and (d))

§17-1737-108 Providers of hospice service. (a) Providers of hospice services shall meet applicable state and federal licensing and the certification requirements of chapter 17-1736 including certification by medicare to provide hospice service.

(b) Providers of service shall enter into a contractual agreement with the state medicaid agency. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: 42 C.F.R. §431.107, 42 U.S.C. §1396(a) and (d))

§17-1737-109 Appeals and hearings. (a) An appeal and hearing shall be available to providers of hospice service in accordance with chapter 17-1736.

(b) An appeal and hearing for applicants and recipients shall be available in accordance with chapter 17-1703. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: 42 U.S.C. §1396(a) and (d))

§§17-1737-110 to 17-1737-114 (Reserved).

SUBCHAPTER 10

SUBACUTE CARE

§17-1737-115 Purpose. The purpose of this subchapter is to describe a level of care needed by a patient not requiring inpatient acute care, but who needs more intensive nursing care than is provided at the skilled nursing level of care.
[Eff 11/25/96] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: HRS §346-14)

17-1737-116 Definitions. For the purpose of this subchapter:

"Acute care hospital services" means services ordinarily furnished in a licensed and certified hospital for the care and treatment of inpatients and does not include skilled nursing facility and intermediate care facility services.

“Baseline status” means that the patient reached a level of condition where no further medical adjustments are indicated except for adjustments for growth and development.

“Dynamic care” means care for pediatric patients which includes a pattern of continuous change and growth in treatment.

"Freestanding " means a medical institution that is not part of a parent medical institution or a medical institution that is separated geographically from the parent medical institution.

“Inpatient acute care” means inpatient acute care as defined by a nationally accepted severity and intensity standards (for example: interqual severity and intensity screening standards).

“Not at risk for rapid deterioration” means individuals that can be placed in a non-acute care setting without risk to the individuals’ health and safety.

“Pediatric” means individuals from twenty-eight days to twenty-one years of age.

"Skilled nursing facility or SNF" means a facility that is licensed and certified as meeting the requirements of participation to provide skilled nursing.

"Subacute" means a level of care that is needed by a patient not requiring acute care, but who needs more intensive skilled nursing care than is provided to the majority of patients in a skilled nursing facility. [Eff 11/25/96; am 06/19/00] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: HRS §346-14)

§17-1737-117 General provisions. (a) Beds shall be specifically certified for subacute care and costs for providing subacute services shall be shown separately on the facility's cost report. Each participating facility shall be required to establish a subacute unit (SACU) as follows:

(1) Freestanding SNF - A minimum of six to a maximum of sixty beds; or

(2) Acute care hospital - A minimum of six to a maximum of sixty beds or more with the department's approval.

(b) The facility shall accept and retain only those subacute patients for whom it can provide adequate care.

(c) The facility shall maintain complete and accurate patient information, in sufficient detail to provide for continuity of care, for patients transferred to a subacute unit.

(d) The freestanding SNF shall maintain written agreements with one or more acute care hospitals to ensure that the acute services are accessible in emergency situations and to facilitate the transfer of patients.

(e) The subacute unit shall have provisions for twenty-four hour emergency services including but not limited to laboratory, radiology, respiratory therapy, and pharmacy services, and if necessary, ventilator support by qualified respiratory technicians.

(f) The subacute unit shall make arrangements for emergency medical care as needed and shall consult with the attending physician or designee when available. Pulmonologist consultant shall be available twenty-four hours a day for telephone consultations and visits or both whenever a facility has ventilator patients. The telephone numbers of those physician(s) shall be posted in a conspicuous area in the subacute unit.

(g) Freestanding subacute units shall be licensed specifically as freestanding subacute units in the State of Hawaii by the department of health.

(h) The facilities caring for group III and group IV pediatric patients shall provide all mandated developmental and educational services.

(i) The department through its medical consultants will determine the medical necessity of the subacute level of care for patients who do not have a medically justified need for the acute level of care, do not qualify for the skilled nursing facility (SNF) level of care, or the intermediate care facility (ICF) level of care, and who meet the criteria of the subacute level of care and cannot be discharged from the acute care facility. [Eff 11/25/96; am 06/19/00] (Auth: HRS §346-14; 42 C.F.R §431.10) (Imp: HRS §346-14)

§17-1737-118 Staffing standards. (a) For the purpose of this section, each licensed nursing staff shall be counted as one. Each subacute unit shall be under the supervision of a registered nurse twenty-four hours a day.

(b) Subacute units authorized to provide care to respirator or ventilator dependent patients shall provide a minimum daily average of 9.0 nursing care hours of which 5.0 hours shall be provided by the nursing staff. Where there is a mix of ventilator-dependent and other patients, the facility shall provide no less than 5.0 licensed and certified hours per patient per day. Subacute units without ventilator patients shall employ sufficient licensed staff to provide a minimum daily average of 5.0 licensed and certified nursing hours.

(c) The department may require a facility to provide additional staff in accordance with subsection (b).

(d) Registered nurses and licensed practical nurses shall have a minimum of six months experience (within the past two years) in a direct participatory general acute care facility where the caseload included patients requiring intensive care and the use of special equipment. Completion of a department of human services approved subacute training course may be substituted for this requirement.

(e) The experience stated in subsection (d) or substitute clinical training for licensed nurses shall include respirator and tracheostomy care, nasogastric tube and gastrostomy care, administration of total parenteral nutrition and traction care. In addition, this requirement shall be completed prior to treating

subacute patients. Registered nurses shall be certified by the facility to perform intravenous procedures and cardiopulmonary resuscitation.

(f) The facility shall provide documentation that all staff participating in direct patient care, including the director of nursing, registered nurses, licensed practical nurses, and nurse's aide staff have continuing in-service training pertinent to the subacute level of care and shall make documentation available upon request by the department of human services at the time of the facility inspection. [Eff 11/25/96] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: HRS §346-14)

§17-1737-119 Physician services. Physician services shall include, but not be limited to:

(1) The evaluation and completion of forms used to establish and continue the subacute level of care for a recipient;

(2) Physicians visits at least weekly during the first month and a minimum of once every two weeks thereafter until the stability of the patient's condition allows for monthly visits;

(3) A plan of care shall be entered into the medical record and shall include:

(A) Medical history, physical findings, and diagnosis indicating the need for admission;

(B) A description of the functional level of the patient;

(C) Objectives to be achieved by the plan of care;

(D) Any orders for medications, treatments, restorative, and rehabilitative services, activities, therapies, social services, therapeutic diet, and special procedures recommended for the health and safety of the patient;

(E) Plans for continuing care, including review and modification to the plan of care;

(F) Plans for discharge, including responsible family member or care givers; and

(G) The attending or staff physician and other personnel involved in the recipients care shall review each plan

of care at least every thirty days. [Eff 11/25/96] (Auth: §346-14; 42 C.F.R. §431.10) (Imp: HRS§346-14; 42 C.F.R. 431.10, 440.50, 456.60, 456.80, 456.250)

§17-1737-120 Subacute patient care characteristics. (a) To qualify for subacute level of care under group I, patients, age twenty-one years and older, must be medically stable and require continuous mechanical ventilation for at least fifty per cent of each day.

(b) To qualify for subacute level of care under group II, non-ventilator patients, age twenty-one years and older, who require a higher level of service than SNF, but who do not require acute hospital care, must be medically stable and require the following services:

(1) Tracheostomy care with suctioning required at least once an hour;

(2) Any combination of mechanical ventilation, tracheostomy care with suctioning and inhalation treatment with or without oxygen at least once a shift;

(3) Total parenteral nutrition;

(4) Continuous intravenous therapy for the administration of therapeutic agents or hydration, or intermittent IV therapy for the administration of therapeutic drugs at least once a shift through a peripheral or central line or both. Therapeutic agents are to include antibiotics, non-vescicant oncology chemotherapy, and analgesics;

(5) Stable newborns or premature infants under age one, who have been inpatients in the acute hospital for at least a week and cannot be discharged because they require any of the following services:

(A) Monitoring episodes of bradycardia and apnea which are resolved by manual stimulation in infants for whom discharge from a facility is medically inappropriate; or

(B) Nasogastric tube or gastrostomy feedings;

(6) Stable patients admitted to the acute care hospital for infections, who are afebrile for twenty-four hours on intravenous or parenteral antibiotics and undergoing

twenty-four to forty-eight hour trials of oral antibiotics or being trained to infuse parenteral antibiotics in the home in preparation for discharge to the home;

(7) Two or more of the following services:

(A) Tracheostomy care with suctioning required at least once a shift;

(B) Traction and pin care for fractures (Bucks Traction is not included);

(C) Medically necessary isolation precautions as recommended by the Centers for Disease Control. (Infection control measures for the care of decubitus ulcers do not apply in this category);

(D) Debridement, packing, and medicated irrigation with or without whirlpool treatment, aseptic dressing changes, management of extensive (stage III) decubitus ulcers or wound infection, and JP drains;

(E) Skilled nursing services including but not limited to the monitoring, observation, and care of patients with HIV infection/AIDS, patients who have terminal diseases, patients who require chronic dialysis treatment, patients receiving radiation therapy, patients receiving treatment for dehydration or monitoring of hydration, or patients receiving treatment for pain control who have or are at high risk for significant medical complications;

(F) Skilled nursing care including observation, monitoring for the side effects of treatment for patients receiving radiation therapy, or the monitoring of hydration and pain control who have or are at high risk for significant medical complications;

(H) At least daily ventilation or inhalation therapy services or both with or without oxygen;

(I) Treatment of patients with eating disorders including bulimia and anorexia nervosa who require skilled supervision and monitoring of food intake and psychiatric inpatient care and are medically stable in the inpatient

facility, but who are at high risk of medical complications if discharged to outpatient care; or

(J) Treatment of psychiatric patients who are not an immediate danger to themselves or others, but who require inpatient monitoring, supervision, and psychiatric care because of high risk for life-threatening complications to themselves or others if discharged to outpatient care; or

(c) Group III pediatric patients who no longer require inpatient acute care, must be at baseline status, and not at risk for rapid deterioration. Requires dynamic care meeting the following:

(1) Weekly medical interventions and monitoring; and

(2) Twenty-four hours a day skilled nursing;

(3) Types of interventions required in group III pediatric subacute level of care are:

(A) Pediatric patients who are ventilator dependent;

(B) Tracheostomy care with skilled interventions (e.g. suctioning greater than once in an eight hour shift.

(d) Group IV pediatric patients who no longer requires acute care, must be at baseline state, and not at risk for rapid deterioration. Requires chronic care meeting the following:

(1) Medical interventions and monitoring at least weekly; and

(2) Skilled nursing intervention at least once per shift.

(3) Types of interventions required in group IV pediatric subacute level of care are:

(A) Continuous intravenous therapy for administration of therapeutic agents or hydration, or intermittent IV therapy for the administration of therapeutic drugs at least once a shift through a peripheral of central line (antibiotics, nonvesican oncology chemotherapy, and analgesics, TPN).

(B) Two or more of the following services:

(i) Tracheostomy care with suctioning not more than once in an eight hour shift and does not require continuous monitoring;

(ii) Debridement, packing, and medicated irrigation, aseptic dressing changes, extensive care of decubiti (stage III), or wound infection and drains.

(iii) Skilled supervision and monitoring of nutritionally compromised patients with eating disorders at high risk of medical complications if managed in an outpatient setting;

(iv) At least daily inhalation therapy by skilled staff; or

(v) Multiple (two or more modalities) rehabilitative services required daily with short and long term attainable goals.

(e) Admission to the subacute level for individuals who require other services shall be made on a case-by-case basis. [Eff 11/25/96; am 06/19/00] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: HRS §346-14)

§17-1737-121 Exclusions. Subacute payments shall not be made for the following patients:

(1) Patients who are medically unstable and require acute inpatient care in an acute care hospital; or

(2) Patients whose level of care is appropriately level C (SNF), level A (ICF), level B (ICF-MR), or lower. Included in this group are the following:

(A) Stable newborns or premature infants under one year of age who require training of the sucking reflex and monitoring of weight and oral feeding to gain weight sufficient for discharge to the home setting;

(B) Stable children, newborns, or infants under the care of the child protective services awaiting placement; and

(C) Patients in terminal phases of disease who request or whose legal guardians have requested in writing the desire not to be resuscitated and no subacute services have been or will be rendered.

[Eff 11/25/96] (Auth: HRS

§346-14; 42 C.F.R. §431.10) (Imp: HRS §§346-14, 346-59)